Supreme Court, U.S.

961849 MAR 2 1 1997

No:
OFFICE OF THE CLERK

UNITED STATES SUPREME COURT

OCTOBER TERM, 1996

JOHN H. LARY, JR., M.D.,

Petitioner,

vs.

SHIRLEY CHATER, COMISSIONER OF SOCIAL SECURITY,

and

SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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65 pp

QUESTIONS PRESENTED

1. What protections, if any, are afforded to Medicare beneficiaries and their physicians and what limitations, if any, are placed by the Constitution, statutes, and regulations of the United States against government agency's obtaining copies of physician's confidential patient medical records?

2. Where Medicare carrier (acting as government agency's intermediary) makes pre-payment review of Medicare claim forms, determines from medical information contained thereon that all medical services billed for are medically necessary and covered under Medicare program, and pays claims, but then later selects claim for "post-payment comprehensive medical review" (i.e. random audit of confidential medical records) and demands physician forward copies of his patients' confidential medical records and where physician refuses or is unable to do so, may Medicare carrier then retroactively make "determination" that physician's medical services are "noncovered by Medicare" program for sole reason that, "No medical records submitted for review?"

3. May Appeals Council dismiss (and courts affirm) petitioner's appeal as untimely filed where (i) copy of ALJ decision was not ever mailed to petitioner's attorney of record and government does not allege or argue that attorney was ever served, and (ii) where only evidence in file relating to date of petitioner's actual date of receipt of his claimant's copy of decision is (a) March 26 date printed on last page of decision (but where court failed to comment that April 20 date is printed on first page of decision) and (b) petitioner's sworn affidavit attesting to long delay in actual receipt of decision and to his timely filing shortly after actual receipt?

4. Does it violate Constitution or laws for administrative law judge to deny any pre-hearing discovery to non-government party and to give blanket denial of subpoena power to claimant?

5. Is government agency's burden greater when it takes away Medicare payments already made than where is refuses to make such payments in first instance?

6. May government agency impose on physicians who treat Medicare patients medical record-keeping requirement in excess of requirement to report medical procedure code numbers and ICD-9-CM diagnostic code numbers on Medicare claim forms?

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1996

PETITION FOR WRIT OF CERTIORARI

Petitioner respectfully requests that a writ of certiorari issue to review the judgment below.

OPINIONS BELOW

The opinion of the United States court of appeals appears at Appendix A and is unpublished. The opinion of the United States district court appears at Appendix B and is unpublished. The order of the Appeals Council appears at Appendix C. The United States court of appeals denial of petition for rehearing appears at Appendix D. The Supreme Court order enlarging time to petition for writ of certiorari appears at Appendix E. The instructions of the Clerk of the Supreme Court directing the petitioner to reprint the petition appears at Appendix F. The letter of the Medicare carrier demanding production of the medical records for carrier audit appears at Exhibit G. The Medicare carrier's letter of decision and overpayment refund demand appear at Exhibit H.

JURISDICTION

Petitioner seeks review of September 16, 1996 order of Eleventh Circuit Court of Appeals affirming district court order dated September 27, 1995 affirming Appeals Council dismissal dated October 14, 1993 affirming two ALJ decisions, (i) for docket no. 000-40-1076, affirming in part (i.e. affirming $4,616.43 of $28,729.30 initially claimed) Medicare carrier's determination dated March 12, 1990 that petitioner had been "overpaid," amount of $28,729.30 and affirming carrier's recoupment actions based thereon, and (ii) for docket no. 000-49-0156 affirming carrier's determination dated August 31, 1988 that petitioner had been overpaid $1,421.09 and affirming carrier's recoupment action based thereon. Petition for rehearing of that Court of Appeals order was denied by Eleventh Circuit on November 25, 1996. On February 20, 1997, Justice Kennedy granted an extension of time until March 21 1997, to file petition for a writ of certiorari. Petition was filed postmarked March 21, received on March 24, 1997,

and returned on March 25, 1997 for reprinting in corrected form within 60 days of March 25, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. Sec. 1254(1) and 28 U.S.C. Sec. 2350. Section 405(g) of Social Security Act and 42 U.S.C. Sec. 405(g) and 42 U.S.C. Sec. 1395ff provide jurisdiction for district court review of Medicare claims disputes.

Notifications of the Solicitor General of the United States, the Commissioner of Social Security, and the Secretary of Health and Human Services required under Rule 29.4(b) or (c) have been met.

CONSTITUTION, STATUTES, REGULATIONS

FIRST CONSTITUTIONAL AMENDMENT

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

FOURTH CONSTITUTIONAL AMENDMENT

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the person or thing to be seized.

FIFTH CONSTITUTIONAL AMENDMENT

No persons shall be held to answer for a capital, or otherwise infamous crime, unless on presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

THIRTEENTH CONSTITUTIONAL AMENDMENT

Section 1. Neither slavery nor involuntary servitude, except as punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.
Section 2. Congress shall have the power to enforce this article by appropriate legislation.

MEDICARE ACT

42 U.S.C. Sec. 1395
Nothing in this title [42 USCS Sec. 1395 et seq.] shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner is which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

PAPERWORK REDUCTION ACT

44 U.S.C. Sec. 3501
The purpose of this chapter is -
(1) to minimize the Federal paperwork burden for individuals, small businesses, State and local governments, and other persons;
...
(6) to ensure that the collection, maintenance, use and dissemination of information by the Federal Government is consistent with applicable laws relating to confidentiality, including section 552a of title 5, United States Code, known as the Privacy Act.

44 U.S.C. Sec. 3507(f)
An agency shall not engage in collection of information without obtaining from the Director a control number to be displayed upon the information collection request.

44 U.S.C. Sec. 3512
Notwithstanding any other provision of law, no person shall be subject to a penalty for failing to maintain or provide information to any agency if the information collection request involved was made after December 31, 1981, and does not display a current control number

assigned by the Director, or fails to state that such request is not subject to this chapter.

44 U.S.C. Sec. 3518(a)
Except as otherwise provided in this chapter, the authority of an agency under any other law to prescribe policies, rules, regulations, and procedures for Federal information activities is subject to the authority conferred on the Director by this chapter.

44 U.S.C. Sec. 3518(c)(2)
This chapter applies to the collection of information during the conduct of general investigations (other than information collected in an antitrust investigation to the extent provided in subparagraph (C) of paragraph (1)) undertaken with reference to a category of individuals or entities such as a class of licensees or an entire industry.

REGULATIONS

42 C.F.R. Sec. 405.870
A party to an initial determination, informal review or hearing may as provided in Sec. 405.803 through 405.934, may appoint as his representative in any such proceeding any person qualified under Sec. 405.871. Where the representative is an attorney, in the absence of information to the contrary, his representation that he has such authority shall be accepted as evidence of the attorney's authorization to represent a party.

42 C.F.R. Sec. 405.872
A representative, appointed and qualified as provided in accordance with Sec. 405.870 and 405.871, may make or give, on behalf of the party he represents, any request or notice relative to any proceeding before the carrier including review and hearing. ... Notice to any party or any action, determination, or decision, or request to any party for the production of evidence, shall be sent to the representative of such party.

42 C.F.R. Sec. 424.32
Basic requirements for all claims
(a) A claim must meet the following requirements:
(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by HCFA in accordance with HCFA instructions.

(2) A claim for physician services must include appropriate diagnostic coding using ICD-9-CM.
(3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with Sec. 424.36(b)).
(4) A claim must be filed within the time limits specified in Sec. 424.44.
(b) The prescribed forms for claims are the following:....
HCFA - 1500 – Health Insurance Claim Form.
(For use by physicians and other suppliers to request payment for medical services.)....

20 C.F.R. Sec. 950(d)
Subpoenas. (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

20 C.F.R. Sec. 404.1715
Notice or request to a representative
(a) We shall send your representative -
(1) Notice and a copy of any administrative actions, determinations, or decisions; and
(2) Requests for information or evidence.
(b) A notice or request sent to your representative will have the same force and effect as if it had been sent to you.

STATEMENT OF THE CASE

The petitioner, Dr. John Lary, Jr., M.D., is a physician, educated at Yale University, where he received his Bachelor of Sciences degree in Molecular Biology and Biophysics, and Tulane Medical School, where he received his medical degree, and further trained in in field of internal medicine for four additional years at Charity Hospital in New Orleans, where he completed internship and internal medicine residency program. Dr. Lary has practiced his specialty of internal medicine in Huntsville, Alabama for more than twenty years and has, also for more than twenty years, taught medical students as a member of the volunteer faculty of the Huntsville campus of the

University of Alabama Medical School. Dr. Lary has an extensive medical practice which includes many Medicare beneficiaries. As a physician licensed by the state of Alabama and as a member in good standing of his local and state medical societies and of American Medical Association, Dr. Lary is ethically and legally bound to respect and guard the confidentiality of all his patient's medical records.

This case began when Dr. Lary treated numerous Medicare patients during the time period October 1, 1988 through September 30, 1989, prepared Medicare claim forms (listing procedure code numbers for the medical services he provided and diagnostic code numbers identifying medical reasons each of the services was needed) and submitted claims to Medicare carrier or intermediary for payment. The carrier reviewed Dr. Lary's claim forms, found them all acceptable, and paid them. Subsequently, Dr. Lary received letter from carrier dated January 8, 1990 notifying him that he had been selected for "post-payment comprehensive medical review" of a sample of his medical records for October 1, 1988 through September 30, 1989 time period (Exhibit G). That letter directed Dr.Lary to copy, at his own expense, a large number of his medical records (listing of medical records demanded by carrier was twenty-four pages long) and directed him to send the copies to carrier's Birmingham headquarters. Dr. Lary objected to carrier's demand, but offered to permit carrier to view original medical records in his Huntsville office, *provided* carrier could provide Dr. Lary with citation to legal authority under which it sought release of these records. Carrier did not provide Dr. Lary with any such citation to law which requires physicians to comply with its demand or which permits physicians to provide copies of confidential records to carrier. The carrier did not attempt to schedule appointment to view original medical records in Dr. Lary's office, but did telephone Dr. Lary to warn him that his continued failure to send the records to carrier's Birmingham office would result in adverse audit finding, which would in turn result in an overpayment determination which would be billed to Dr. Lary. Dr. Lary continued to refuse to send records, and carrier subsequently notified Dr. Lary by letter dated March 12, 1990 that review had been conducted and that "It was determined that you were billing for services that were noncovered by Medicare" and that "Our medical review identified an overpayment in the amount of

$28,729.30." (Exhibit H). Sole reason given by carrier for its determination was its statement that, "No medical records submitted for review." Carrier demanded repayment of the $28,729.30, which sum represented its statistical projection of all of the Medicare payments the carrier had made to Dr. Lary during that year's period under review.

Dr. Lary contested the carrier's determination, and appealed for Medicare Part B Fair Hearing, hiring an attorney to represent him and notifying Social Security Administration of attorney's name and address by filing proper Social Security form SSA 1696-U4 (page 225 of transcript for docket 000-40-1076). After obtaining permission from many of his patients for disclosure of their medical records at the hearing, Dr. Lary and his attorney filed as exhibits to the Medicare Part B Fair Hearing photocopies of many of the medical records which the carrier had demanded. Hearing officer gave Dr. Lary's exhibits to Medicare carrier representative with instructions to carry out a new audit. As a result of those medical records exhibits which were now available to carrier, it revised its overpayment determination downward from $28,729.30 to the revised sum of $5,616.22, which sum was adopted by hearing officer as his decision of Medicare Part B Fair Hearing. Dr. Lary objected to revised finding, and appealed this new determination for administrative law judge review. While awaiting ALJ hearing, carrier seized $5,616.22 plus interest from money it owed to Dr. Lary because of other services he had provided to other Medicare beneficiaries.

Administrative law judge scheduled hearing for this case (Docket No. 000-40-1076) to be held simultaneously with another of Dr. Lary's pending cases (Docket Number 000-49-0156, involving technical issues not related to patient medical records confidentiality). Dr. Lary made written request to Administrative law judge for permission to engage in pre-hearing discovery by serving interrogatories and request for admission of facts upon Health Care Financing Administration, but permission for this or for any other discovery was denied. Dr. Lary made written request for issuance of subpoena compelling appearance at hearing of adverse witnesses (i.e, carrier officials), but office of administrative law judge, by telephone call, refused to permit issuance of subpoena for requested witness or for any other witness or witnesses (page 442 of transcript of docket 000-40-1076). Oral hearing was held on February

20, 1992, where Dr. Lary's examination of auditor who conducted review for carrier forced her to admit that she had simply overlooked some of the medical records she had reviewed, with result that administrative law judge reduced overpayment amount by $999.79, from $5,616.22 to $4,616.43. The administrative law judge, however, did not agree with Dr. Lary's arguments that it is those services a physicians actual performs, (rather than opinion of auditor, based on no identifiable standards, as to what level of services the words written in physician's medical records "document") that governs payment under Medicare program. The administrative law judge did not agree with Dr. Lary's arguments that it those laboratory services a physicians actual performs and acts upon at the time a patient is treated (even if physician later refuses or fails to produce laboratory report to carrier) that governs payment under Medicare program (so long as services are appropriate for diagnosis treated). In these kinds of instances, the administrative law judge agreed with the carrier auditor's position that, even if carrier auditor and administrative law judge both believe that services billed by physician were actually performed, physician's subsequent loss or misplacement of laboratory reports or his poor record-keeping or his failure or refusal to divulge confidential medical records was grounds for retroactive reduction or denial of Medicare payments already made.

Pages 66 through 71 of the testimony transcript of the Administrative Law Judge Hearing show that the Medicare carrier auditor "downcoded" some of Dr. Lary's office visit services because his medical records "documenting" the office visits were "not adequate" for the level of office visit service that Dr. Lary coded for and billed for (i.e., the Medicare auditor allowed payment for a lesser degree of office visit service because she could not find in Dr. Lary's records written "documentation" to support the degree of office visit service which Dr. Lary coded for and billed for). Those pages also show that the Medicare auditor also disallowed other services because she could find no "documentation" of the service being performed. And, at pages 100 and 101, the Medicare auditor asserts (and the Administrative Law Judge agreed) that the lack of a "lab slip" (i.e., laboratory report) in the case file requires the Medicare carrier to make post-payment disallowance for the laboratory service.

Page 70, the questioning of the Medicare carrier auditor by Dr. Lary, goes as follows:

> (Dr. Lary) Q Yes. And you also, for instance, some of the office visits -- when you downcoded an intermediate office visit to a limited office visit, you thought the documentation didn't support the intermediate office visit. Is(n't) that correct?
> (Ms. Kerzic) A That's correct.
> (Dr. Lary) Q But you are not saying that I did not perform an intermediate office visit, that's --
> (Ms. Kerzic) A I never said that you didn't perform it, I said you didn't document it.
> (Dr. Lary) Q Alright, I understand. I'm just making this clear for the record. It is a -- strictly a problem as you see it, with my documentation, and you're not saying that the service was not performed--
> (Ms. Kerzic) A Yes.
> ALJ Nobody is calling you a liar.

And page 100 contains an exchange between Dr. Lary and the Administrative Law Judge concerning the judge's opinion that "documentation" of laboratory test results on audit is required for payment by Medicare. The exchange goes:

> (Dr. Lary) CLMT Right, but lab (reports) do get lost and that happens in hospitals and offices.
> ALJ Well, you are not going to tell her (referring to the Medicare carrier auditor) that she is responsible for paying what, for what (is) lost.
> (Dr. Lary) CLMT But it was not lost at the time the (patient was treated) is what I am saying.
> ALJ That may or may not be. You know, this is -- I can quite understand that maintaining records is very difficult, and often things do happen, and that you can -- nobody is saying that you did not do the test, but the regulations require that there be documentation, and if it is not there you have to lose it, so what can you do?

The administrative law judge rendered two decisions, both dated March 26, 1992. Neither decision

was ever mailed to Dr. Lary's attorney[1], and the government has not alleged or even argued that Dr. Lary's attorney was ever sent a copy of either of the ALJ decisions. Dr. Lary was mailed copy of both decisions, which arrived by mail at his office contained in same envelope. Dr. Lary, by letter dated July 22, 1992, appealed both ALJ decisions to Appeals Council of Social Security Administration. Appeals Council wrote to Dr. Lary that his appeal was not filed within prescribed 60 day time limit. Dr. Lary wrote back that he had not received decisions until long after March 26 date written on decisions and that his July 22 appeal (filed on July 28) was filed well within 60 days of actual receipt of decisions. Dr. Lary buttressed his letter with his sworn affidavit, but Appeals Council dismissed Dr. Lary's appeal of both cases on grounds of untimely filing. The only evidence in the file in support of Appeals Council's dismissal is the presence of March 26 date written on the decisions. There are no affidavits in the file other than Dr. Lary's.

Dr. Lary appealed to district court, addressing threshold issue of Appeals Council's presumption of timely delivery by pointing out on page 11 of his brief that Dr. Lary's sworn affidavit as to delivery date of ALJ decision is the only sworn testimony in the case and, on page 12, that "there is no evidence anywhere in existence other than the testimony of the recipient as to date of receipt of mail." Despite government's lack of affidavit or testimony attesting to date of actual mailing or attesting to usual office procedure with respect to mailing so that date of actual mailing could be inferred (which is prerequisite for presumption of timely mail delivery under well settled legal doctrine), District Court affirmed Appeals Council dismissal for untimely filing. Dr. Lary also addressed the merits of his case in district court, arguing that government agency had violated federal statute, Paperwork Reduction Act, 44 U.S.C. Section 3501 et seq., because such decision imposed an illegal record-keeping and record disclosure requirement on Dr. Lary and because agency's original

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[1] Possible reason for failure of ALJ to mail decision to Dr. Lary's attorney was the failure of Office of Hearings and Appeals to write the name and address of Dr. Lary's attorney in box provided for claimant's representative on Notice of Hearing form HA-507-U4 (page 29 of transcript of docket 000-40-0176).

demand for medical records was a "bootleg request." Dr. Lary also argued that ALJ decision violated Administrative Procedure Act and that due process requirement of Constitution had been violated. District court on September 27, 1995, granted government's motion for summary judgment.

Dr. Lary appealed to court of appeals, which found his arguments to be as non-persuasive as had district court. Appellate court also dismissed Dr. Lary's argument that the failure of the office of hearings and appeals to mail a copy of ALJ decisions to Dr. Lary's attorney of record (as is required by regulation[2]) tolls 60 day statute of limitations. On September 6, 1996, court of appeals affirmed district court's dismissal. Dr. Lary petitioned for rehearing, but that petition was denied on on November 25, 1996. Dr. Lary applied to Supreme Court for for extension of time within which to file a petition for writ of certiorari, which was granted by Justice Kennedy on February 20, 1997, extending the time to and including March 21, 1997.

REASONS FOR GRANTING THE WRIT

This case is important to society as a whole because it addresses the limits and restrictions placed by law upon the government's ability to compel physicians and their patients to disclose confidential patient medical records to government agency intermediaries. A common but illegal practice of agents of government agency is at issue, and a decision in this case may serve to restrict or abate illegal agency practices. The court of appeals, in permitting government agency intermediary's actions with respect to breach of confidentiality of medical records, has so far departed from the accepted and usual course of judicial proceedings as to call for an exercise of the Supreme Court's supervision.

There is strong reason to settle this issue by deciding this case now because no better case is likely to appear and because the federal government's role in providing health insurance is likely to expand in the near future, resulting in expanded opportunity for government carriers to demand and obtain confidential medical records illegally but under color of law.

This case is the story of what happens to a physician if he should recognize ethical and legal

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[2] 20 C.F.R. Sec. 404.1715

implications of Medicare carrier's demands for confidential patient medical records and be so foolish, in the face of almost certain defeat, to refuse to buckle under to illegal government agency intermediary's demands. It brings to light heavy handed administrative actions by intermediaries of government agency acting in an official capacity but outside of the law, and reveals absence of effective checks to such illegal conduct either by government agency or by the courts.

This case involves both the rights of patients to be secure in the confidentiality of their medical records, free of interference by government and its agents, and rights of physicians to be secure in their papers and effects, free of government "fishing expeditions."

OVERVIEW OF ILLEGAL GOVERNMENT PRACTICES

Medicare beneficiaries are all required by law to disclose some of the medical information about their medical treatments so that the Medicare program can be properly administered. Physicians who treat Medicare beneficiaries are required by law to collect and report that medical information which is necessary for processing Medicare claims. The Health Care Financing Administration (HCFA) of the Social Security Administration, although it is entitled to that amount of medical information required to process a claim, is not entitled to any medical information in excess of that, and is not empowered to compel physicians to either collect more or report more.

The only medical information to which the government is entitled consists of (i) information identifying the medical procedure performed or medical service provided and (ii) information identifying the diagnosis or diagnoses for which each medical procedure or service was performed, 42 C.F.R. Sec. 424.32,. Social Security Act, and Paperwork Reduction Act, 44 U.S.C. Sec. 3507(f), authorize Social Security Administration to obtain such medical information required to process a Medicare claim by imposing record-keeping requirement upon physicians to collect and report (i) standard medical procedure code numbers (CPT code numbers) for each procedure or service provided and (ii) standard diagnostic code numbers (ICD-9-CM code numbers) for which each medical procedure or service was provided. Physicians are required to report this

information using standard HCFA-1500 claim forms designated for that purpose (which contain OMB control number in compliance with 44 U.S.C. Sec. 3507(f)), 42 C.F.R. Sec. 424.32. Once physician has reported medical information to agency's carrier on HCFA-1500 claim form, physician's responsibility for collection and reporting of medical information is satisfied. The P.R.A. encompasses information collection activity such as Medicare carrier's "post-payment comprehensive medical reviews," which are "undertaken with reference to a category of individuals or entities such as a class of licensees or an entire industry," 44 U.S.C. Sec. 3518(c)(2).

Medical information to which the government agency is not entitled is any and all patient medical information in excess of information contained in the procedure code numbers and in the ICD-9-CM code numbers contained on the HCFA-1500 claim form. HCFA-1500 claim forms, agency's only medical information gathering tool approved by OMB for physician's Medicare Part B services, do not contain any spaces for any medical information other than procedure code numbers and diagnostic code numbers.

Physicians almost always collect in their patient medical records much more medical information about their patients than the information needed for processing Medicare claims. This extra information is confidential, however, and may not ethically or legally be disclosed to any third party (including HCFA or any other government agency) without patient's express consent. The patient's signature in box number 12 of HCFA-1500 claim form authorizes only disclosure of that medical information "necessary to process this claim" (i.e., authorizes disclosure of procedure code numbers and ICD-9-CM code numbers, which identify medical services rendered and medical diagnoses which were treated, but authorizes disclosure of nothing more). For example, when a physician treats a patient for complaint of painful urination (ICD-9-CM code number 788.1) by performing a bacterial culture (procedure code number 87086), patient's signature in box 12 authorized physician to disclose to the Medicare carrier only procedure and diagnostic code numbers. Physician may not, without the patient express consent, disclose more details (i.e., physician, for example, may not disclose whether the bacterial culture performed yielded positive or negative results). These two code numbers are sufficient for

Medicare carrier to determine whether or not the procedure is covered under Medicare program and whether or not the procedure is medically necessity for the diagnosis reported. (Since it is standard medical practice to perform bacterial culture for complaint of painful urination, one would expect the Medicare carrier to approve such claim for payment.)

Good reason for limiting amount of medical information disclosed to procedure code numbers and ICD-9-CM diagnostic code numbers is (i) the highly personal and confidential nature of information contained in patient medical records and (ii) sufficiency of information contained in procedure code numbers and diagnostic code numbers present on HCFA-1500 claim forms to permit administration of Medicare program. A hypothetical example which illustrates follows:

John Q. Public, a well respected 65 year old clergyman from a prominent family living in a conservative community, visits a physician for the first time with complaint of painful urination for past two days. The patient's medical history as recorded in his medical record reveals that patient had sexual intercourse with his wife two days prior to onset of symptoms, and that he suspects sexually transmitted disease because of his wife's habitual illicit extramarital affairs. Further, medical record reveals that patient is currently under psychiatric care for treatment of alcoholism and depression (both related to his wife's promiscuity) and that he smoked marijuana extensively during his college years. Past medical history reveals that patient was subjected to homosexual rape as a child, and was infected with venereal warts of anus as a result. Past medical history further reveals that patient has received surgical penis prosthesis implant for treatment of impotence. Family history and social history records that patient was of illegitimate birth and knows nothing of his biological father's medical history and that the patient, in his youth, fathered an illegitimate child whom he has never seen and who lives in a distant state and with whom patient has never had any contact or provided any financial support. Medical history further records that patient is taking Antabuse (drug for treatment of alcoholism) and amitriptyline (drug for treatment of depression). Physical examination records that patient has spider nevi of back (stigmata of alcoholism), venereal warts of anus (stigmata of anal intercourse at some time in past), penile prosthesis

implant, and purulent discharge from tip of penis (characteristic finding in presence of gonorrhea). Physician's laboratory reports contained in medical record reveal that gram stain of penis discharge showed presence of intracellular gram negative diplococci (characteristic finding in patients infected with gonorrhea) and that complete blood count with differential revealed elevated white blood count with high PMN and presence of bands (characteristic of acute bacterial infection). Electrocardiogram tracing shows characteristic findings of patient with severe heart disease, and physician's interpretation of tracing written on tracing indicates strong suspicion of arteriosclerotic coronary artery disease. Physician's notes reveal that physician also suspected gonorrhea, and sent specimen to outside laboratory for bacterial culture to confirm or rule out gonorrhea, and that physician prescribed oral ampicillin and probenecid (antibiotic regimen which is used in this combination and dose exclusively to treat gonorrhea) while awaiting bacterial culture results. The medical records also show that the physician referred the patient to an out-of-town medical center for balloon angioplasty of his coronary arteries, and that physician expected excellent results from the balloon angioplasty, with minimal time away from work for patient, and that patient planed to take vacation time from work in order to secretly undergo treatment of heart disease. The patient wants none of the details of his medical condition or medical history to be disclosed to anyone, and wants as little information as possible to be disclosed on his Medicare HCFA -1500 claim form.

The physician files Medicare claim for his services, listing diagnosis of painful urination (ICD-9-CM code 788.1) and abnormal electrocardiogram (ICD-9-CM code 794.31), and listing medical procedures and services consisting of (i) comprehensive history and physical examination (procedure code 99205), (ii) complete blood count with differential (procedure code 85022), (iii) Gram stain (procedure code 87205), and (iv) electrocardiogram with interpretation (procedure code 93000). Medicare carrier subjects this medical information to computer analysis which reveals that all procedures and services are covered under Medicare program and which further reveals that all medical procedures and services listed are generally accepted by medical authority as being medically necessary for treatment of diagnoses listed. Medicare carrier pays the claim.

The above hypothetical example demonstrates good reason for law limiting disclosure of confidential medical information to that information necessary to process claim for reimbursement. By limiting disclosure of medical information to procedure code numbers and diagnostic code numbers, the confidentiality of the details of patient medical information beyond that which is necessary for administration of Medicare program is protected. In the above hypothetical case, virtually all of the medical information in the medical record, except for the procedure code and diagnostic code numbers, is highly personal information which could cause embarrassment and adversely affect patient's career and social standing if it were to become known to even a single person. And even the information contained in the code numbers (although less sensitive than other clinical information in his medical record, patient might wish to keep secret his diagnoses of painful urination and abnormal electrocardiogram) present on the HCFA-1500 claim forms is relatively protected, since HCFA claim forms are entered directly into the Medicare carriers' computers without human intervention (and thus are not read by human employed by Medicare carrier), and determination of Medicare coverage and tests for medical necessity are made automatically by computer program without direct human intervention.

Regardless of law limiting agency's right and power to view medical information contained in medical records, it is sad fact that government agency regularly violates patient confidentiality by demanding that physicians, on threat of heavy penalty (retroactive disallowance of all Medicare payments), photocopy their confidential patient medical records and send them to the Medicare carriers for "Post-payment Comprehensive Medical Review" (i.e, government fishing expeditions). The fact that such demand is illegal does not stop HCFA or the Medicare carriers from engaging in such practice on a vast scale. The fact that it is illegal and unethical practice does not stop physicians from complying with illegal demands on similarly vast scale, physicians being as vulnerable to threats and intimidation as any other victims of extortion. (In defense of physicians, it should also be noted that physician's respect for integrity of government's agencies lead vast majority of them to innocently believe that government agency must have legal right to read or to obtain photocopies of Medicare

patient's confidential medical records or else it would not be seeking them.)

One can easily see the ethical and legal dilemma faced by our hypothetical physician who treated our hypothetical 65 year old clergyman patient if he should be unlucky enough to be selected for Medicare carrier's "Post-payment Comprehensive Medical Review." On the one hand, physician is ethically and legally bound to protect the confidentiality of the medical information contained in his medical records. On the other hand, Medicare carrier states that physician must copy all medical records, including all "lab, X-ray, EKG services, diagnostic procedures and any other medical care provided in your office" for the Medicare claims under review. If physician complies with Medicare carrier's demand to be given copy of his patient's confidential medical records, then physician has violated his ethical and legal duty to his patient, and may be subject to lawsuit, legal sanctions, or even professional license revocation action. If physician follows his ethical and legal duty to protect confidentiality of records and refuses Medicare carrier's demand, then Medicare carrier will hold "Post-payment Comprehensive Medical Review" audit of physician's patient medical records without benefit of those medical records and will make "determination" that the Medicare payments previously made were "overpayment" which is due to be refunded by physician. The carrier will justify its refund demand because it will hold that the medical services under "Post-payment Comprehensive Medical Review" were "not medically necessary" and thus "not covered by the Medicare program," justifying such holding by stating reason "no medical records submitted for review." And if physician refuses to refund the "overpayment" amount demanded by the Medicare carrier, the carrier will simply institute a "recoupment" action and withhold all future Medicare payments due to be paid to that physician until sufficient money has been withheld to cover the total amount demanded plus interest. And, if the example of Dr. Lary's case be repeated for out hypothetical physician, appeal for Medicare Part B Fair Hearing, followed by appeal for Administrative Law Judge Hearing, followed by appeal to Appeals Council of Social Security Administration, followed by federal district court appeal, followed by appeal to court of appeals, will be mere expensive and time consuming exercise in futility. Of course, our hypothetical

physician may still embrace the faint hope that the Supreme Court may hear his case, rule against government agency, and order government agency to give him his money back. But all things considered, probably the most practical course of action for our hypothetical physician to follow is to submit photocopies of his patient confidential medical records to Medicare carrier and not be much concerned with ethical and legal implication of that act. After all, the patient will never know of the disclosure, since neither the Medicare carriers nor Social Security Administration ever notify patients that Medicare carrier employees have obtained and read copies of their physician's confidential patient medical records.

ETHICAL AND LEGAL OBLIGATION OF CONFIDENTIALITY

The right of patients to confide in their physician without fear of disclosure has been recognized since the time of the ancient Greeks. The Hippocratic Oath, taken by newly graduating physicians for more than two thousand years, provides, among other things, that the physician will not divulge confidential information, Encyclopedia Britannica, 1959 edition, volume 11, page 585. This ethical principle has been long accepted by the American Medical Association, which has codified it as the fourth of seven Principles of Medical Ethics, a body of ethical statements established by the medical profession primarily for the benefit of patients. That ethical principle of confidentiality is reiterated as the second of four commitments, promulgated by the American Medical Association and made by American physicians to their patients, as follows,"Among my commitments to you, my patient, are ... (II.) to respect your wishes in decisions about your health care and to respect your right to privacy, American Medical Association. The Council on Ethics and Judicial Affairs has further explained the ethical principle in section 5.05 of Code of Medical Ethics, Current Opinions, 1996-1997 edition, page 77 , which begins with the words, "The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree." The patient's right to his physician's confidence, moreover, has been recognized as a medical license requirement by

the State of Alabama, the State in which this petitioner is licensed and practices medicine.

The ethical principle stated in Principle IV and Opinion 5.05 [often cited by the courts using an earlier AMA citation schemes as "Ch. II, Sec. 1 Principles Ch. 1, Sec. 2 (1912)" or as "Principle 9 (1957"] have been recognized as public policy in numerous court decisions.

Citing Principle 9 (1957) [now Principle IV and Opinion 5.05 (1983)] as well as court decisions from other states, Alabama Circuit Court ruled in 1973 that a physician had breached his fiduciary duty of confidentiality by revealing patient information to a third party. The court found that the Principles together with state licensure requirements sufficient to establish the public policy of confidentiality, Horne v. Patton, 291 Ala 701, 287 So. 2d 824, 829, 832. Other courts have found same ethical and legal duty to confidentiality[3]

PATIENT'S CONSTITUTIONAL RIGHT TO PRIVACY

The right of patients to rely upon the privacy of the physician-patient relationship and the confidentiality of their medical records is a fundamental right for Constitutional purposes under approach taken by the Court in Bowers v. Hardwick, 478 U.S. 186, 106 S. Ct. 2841, 92 L. Ed.2d 140 (1986), rehearing denied 478 U.S. 1039, 107 S. Ct. 29, 92 L. Ed.2d 779 (1986). In order to justify finding that a right not mentioned in the Constitution is a fundamental right, a majority of the Justices must be convinced that the right is implicit in the concept of an ordered liberty or that it is protected by the nation's history and traditions. And in Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 770-772, 106 S. Ct. 2169,

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[3] Salt River Project v. Industrial Comm'n, 1992 Ariz. App. LEXIS 323, 129 Ariz. Adv. Rep. 39, Perreira v. State, 768 P.2d 1198, 1210 n.7, Vassiliades v. Garfinkle's, Brooks Bros. 492 A.2d 580, 590, 591, Petrillo v. Syntex Laboratories, Inc., 148 Ill. App. 3d 581, 499 N.E. 2d 952, 957, 958, 959, cert. denied, 483 U.S. 1007 (1987), Wenninger v. Muesing, 240 N.W.2d 333, 337 n.3, State ex. rel. Woytus v. Ryan, 776 S.W.2d 389, 392-93, Doe v. Roe, 93 Misc. 2d 201, 400 N.Y.S.2d 668, 674, Allen v. Smith, 368 S.E.2d 924, 928, In re Rules Adoption, 224 N.J. Super. 252, 540 A.2d 212, 215.

2184-85 (1986) the Court stated a general duty of courts to enforce Constitutional principle "that a certain private sphere of individual liberty will be kept largely beyond the reach of government."

In Griswold v. Connecticut, 381 U.S. 479, 85 S. Ct. 1678, 14 L. Ed.2d 510 (1965), the Court found a right to privacy (the value of privacy had long been a part of American legal philosophy) implicit in several guarantees of the Bill of Rights. With respect to sensitive nature of medical records, it is important to remember that the press cannot be prohibited, consistent with the First Amendment, from reporting information obtained from public records, Cox Broadcasting Corp. v. Cohn, 420 U.S. 469, 95 S. Ct. 1029, 43 L. Ed.2d 328 (1975) and that persons who are not participants in judicial proceedings (even confidential proceedings) are not subject to criminal sanctions for publishing accurate reports of such proceedings, Landmark Communications, Inc. v. Virginia, 435 U.S. 829, 98 S. Ct. 1535, 56 L. Ed.2d 1 (1978).

The Alaska court, in 1977, has ruled that state's Conflict of Interest Law, requiring school board members to disclose names of persons from whom they had received over $100, was unconstitutional when applied to physician school board member (who refused to reveal names of patients from whom he had received more than $100 in medical fees) because Conflict of Interest Law unconstitutionally invaded patient privacy due to absence of protective regulations, Falcon v. Alaska Pub. Offices Comm'n, 570 P.2d 469, 474 n.13.

FIRST, FOURTH, AND FIFTH AMENDMENT VIOLATIONS

Whereas the privacy right discussed above are not specifically stated in the Constitution, but are to be found only in the "penumbra" of the Bill of Rights, patient's privacy rights in their confidential medical records are squarely protected by the text of the Bill of Rights. The Fourth Amendment right of the people to be secure in their papers and effects against unreasonable search and seizure is violated when government agency acquires copies of confidential medical records without express consent of patient and against wishes of physician, without probable cause supported by oath or affirmation. The First Amendment right of the people to free speech and free assembly is restricted where government can

obtain copy of private conversation between physician and patient, since government's power to obtain written notes or summary of conversation, especially where government's agents frequently exercises such power, can have chilling effect on patient's speech and assembly by causing patients to possibly refrain from discussing sensitive private health matters with his physician for fear of subsequent disclosure. Fifth amendment right against self-incrimination is in danger where government enjoys practice of reading confidential medical records.

THIRTEENTH AMENDMENT VIOLATION

Even if Medicare carrier can obtain right to view patients' confidential medical records, it does not follow that Medicare carrier has right to demand that physicians, by their own work and at their own expense, photocopy those records and transport them to another city. That is prohibited by Constitutional prohibition against involuntary servitude. And because Dr. Lary refused to photocopy his medical records and transport them to carrier's Birmingham headquarters, the carrier punished him for such conduct by retroactively disallowing $28,729.30 (later reduced to $4,616.43) and then seizing in excess of $5,616.22 by means of involuntary "recoupment" of funds in its possession belonging to Dr. Lary's account. Since the original finding of $28,729.30 "overpayment" upon which the carrier's later recoupment action is based came about as a direct result of Dr. Lary's refusal to perform for government's agents that act of photocopy and delivery which Dr.Lary cannot legally be compelled to perform, the taking of any part of the $28,729.30 "overpayment" amount violates Due Process requirements of the Constitution.

DECISION IS IN VIOLATION OF PAPERWORK REDUCTION ACT

The Paperwork Reduction Act, 44 U.S.C. Section 3501 et seq., prohibits any agency (including HCFA or its Medicare carrier agents) from conducting or sponsoring the collection of information unless the Director of the Office of Management and Budget has approved such data collection and has issued a control number which must appear in the upper right hand corner of the

information collection request document, 44 U.S.C. Sec. 3507(f). Reporting and record-keeping requirements imposed by the agency are included within the P.R.A., as are oral communications. The P.R.A. also encompasses regulations that require disclosure of information to the government, U.S. v. Smith, 866 F.2d 1092 at 1098 (9th Cir, 1989), 44 U.S.C. Sec. 3518(a).

Answers to identical questions posed to, or identical reporting or record-keeping requirements imposed on, ten or more persons fall under the Paperwork Reduction Act. The "Public protection" clause of the P.R.A., 44 U.S.C. Sec. 3512, prohibits the imposition of any penalty upon any person for failure to comply with any "bootleg request" not bearing an OMB control number.

The Supreme Court, in Dole v. United Steelworkers of America, 494 U.S. 26, 110 S.Ct. 929, 108 L. Ed.2d 23 (1990), applied the P.R.A. to forced availability of records. The provisions of the P.R.A. apply, whether the agency regulations call for information to be sent to an agency or that "records be kept on hand for possible examination as part of a compliance review," see Dole v. Steelworkers at 110 S.Ct. 933. Section 3512 of the P.R.A., the "public protection" section, protects against nonfeasance, U.S. v. Matsumoto, 756 F. Supp. 1361 (D. Hawaii, 1991).

In the instant case, the information collection request is the certified letter of Melissa J. Kerzic dated January 8, 1990, a letter which bears no OMB control number (see Exhibit G). Although the letter does not state that at least nine other persons besides Dr. Lary were subjected by Medicare to identical information reporting and record-keeping requirements, the Medicare Carriers manual indicates that post-payment comprehensive medical reviews are an ordinary part of the activities of Blue Cross Blue Shield of Alabama in its administration of the Medicare program.[4] . And the

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[4] Postpayment Comprehensive Medical Reviews are frequently conducted by Blue Cross Blue Shield of Alabama on the medical records of Alabama physicians. Section 7514 of the Medicare Carriers Manual requires the Medicare carriers to conduct postpayment comprehensive medical reviews on 7.5 physicians/ suppliers per 1000 in the carrier's active providers file every year.

Medicare carrier auditor testified at the Administrative Law Judge hearing, on page 73 of the testimony transcript, that "every other physician in the state furnishes copies of their records" (to the Medicare carrier in response to the carrier's letters requesting them). Clearly, more than nine persons besides Dr. Lary are held by the Medicare carriers to the same information collections request and record-keeping requirement as was demanded of Dr. Lary.

Paperwork Reduction Act is also important in that it serves to limit the patient's authorization contained on box 12 of the HCFA-1500 claim form for release of medical information to only that medical information necessary to process the claim. Since the medical information that is necessary to process a Medicare claim is found in a properly completed HCFA-1500 form and consists of only procedure code numbers and diagnostic ICD-9-CM code numbers, and since government agency's only record-keeping requirements which have been approved by Office of Management and budget is requirement for those procedure code numbers and diagnostic code numbers, it logically follows that patient's authorization for disclosure of medical information is limited to disclosure of those code numbers. The patient's authorization does not include authorization for government agents or employees to view any additional medical information (such as laboratory reports, X-rays, treatment reports, etc.) which may be present in the medical records.

PRE-HEARING DISCOVERY AND DUE PROCESS VIOLATIONS

The Administrative Law Judge refused to permit Dr. Lary to subpoena, not only the witnesses he initially requested in writing, but also refused to permit him to subpoena any witnesses for any reasons whatsoever (see page 442 of transcript for docket 000-40-1076). An administrative agency, however, may not enforce an inflexible rule denying discovery, McLain Industries,Inc. v. NLRB, 381 F. Supp. 187 (E.D. Mich. 1974). And the California court ruled that an agency must provide pre-hearing discovery as an element of fair procedure, Shivley v. Stewart, 421 P.2d 65 (Cal. 1966). And Social Security regulations, 20 CFR sect. 404.950(d), requires issuance of subpoena

for witnesses and documents "when it is reasonably necessary for the full presentation of a case."

Administrative Procedure Act, 5 U.S.C. Sec. 551 et seq, mandates that agency show due regard for the necessity of the parties. Dr. Lary had no effective way other that interrogatories and request for admission of facts to bring evidence as to HCFA's (as opposed to carrier's) position with respect to certain technical question before Administrative Law Judge. Dr. Lary had no effective way to compel appearance of adverse witness employed by carrier (whose testimony would show that carrier's position with respect to certain technical coding questions was inconsistent in that carrier's medical director, Dr. Wigginton, permitted Dr. Lary's method of coding while auditors did not. And the only other avenue open to Dr. Lary to introduce evidence as to this carrier inconsistency was to introduce at the Administrative Law Judge Hearing the findings and conclusions of an earlier audit to which Dr. Lary had been subjected (and which dealt with same coding question) and which findings and conclusions were in Dr. Lary's favor. Administrative Law Judge, however, refused to permit introduction of any evidence as to findings and conclusions of a previous audit, even though those findings and conclusions would have excused Dr. Lary, under concept of "waiver of liability," from any obligation to repay. But 20 CFR sect. 404.944 requires Administrative Law Judge to "accept as evidence any documents that are material to the issues."

PHYSICIAN'S MEDICAL RECORDS NEED NOT MEET CARRIER IMPOSED STANDARDS

The assertion, by both the Medicare carrier auditor and by the Administrative Law Judge, is specious that "the regulations" (just which regulations is left unstated) require physicians to create and maintain "documentation" (i.e., office visit notes, laboratory reports, X-ray reports, treatment reports, etc.) in their confidential medical records sufficient to satisfy carrier auditor's standards (whatever those standards may be) as to "documentation" of the level of services rendered to Medicare patient. There are no regulations which require Dr. Lary to keep medical records at all (other than requirement to record procedure code numbers and diagnostic code numbers [i.e., ICD-9-CM code numbers] on HCFA-1500 claim form) and there are no regulation

requiring Dr. Lary to photocopy for the benefit of the government any confidential medical records that he does keep for his own use. Even if a doctor does choose to keep medical records for his own and his patient's benefit, those records are highly confidential and the federal government has no statutory or regulatory basis upon which to either regulate their contents or to demand their production for purposes of carrier's "post-payment comprehensive review."

Notwithstanding the Medicare auditor's and the Administrative Law Judge's contention, reinforced by their decisions and actions, that there are legal documentation standards or record-keeping standards which empower it to justify an "overpayment" recoupment for Dr. Lary's failure to satisfy those standards, case law, in Glick v. Secretary. H.H.S., 714 F. Supp. 39, CCH Medicare/Medicaid Guide at 37,895 (D. Mass, 1989) holds to the contrary. In Glick, the court found that Medicare was not entitled to recover overpayments from a physician (there a psychiatrist) based on insufficient records and documentation. Although the physician had received notices from his carrier of "documentation requirements," these, said the court, did not impose a particular record-keeping content requirement or justify recovery of reimbursement based upon a violation of the documentation notices. (Although both the Administrative Procedures Act and the Paperwork Reduction Act lead to the same conclusion, the decision in Glick did not cite, and the court did not base its decision on, either Act. It was decided solely on the absence of any statute or regulation requiring that physicians make or maintain any medical records in order to be paid for their services to Medicare beneficiaries) Dr. Lary cited the Glick decision in his brief to the Administrative Law Judge (see Exhibit 19 to Docket No. 000-40-1076, court transcript page 402). Dr. Lary has also cited the government's violation of the Paperwork Reduction Act, the Administrative Procedure Act, and the Federal Register Act to the Office of Hearings and Appeals (see court transcript page 11 of Docket No. 000-40-1076). Dr. Lary has continued to fruitlessly cite Glick decision and Paperwork Reduction Act and Administrative Procedure Act as he appealed to district court and to court of appeals.

AGENCY'S POST-PAYMENT BURDEN IS GREATER

It is well established, going back to Article 39 of Magna Carta, that the government's burden is greater when it seeks to take action against a citizen than when it denies a request. This applies to revocation of parole as against denial of parole, Morrissey v. Brewer, 408 U.S. 471, 481-882 (1972), to deportation of aliens as against denial of entry, Woodby v. Immigration & Naturalization Serv., 385 U.S. 276, 286, to termination of month-to-month tenancy in public housing as against denial of tenancy, Brown v. Housing Authority, 340 F. Supp. 114, aff'd 471 F.2d 63 (7th Cir. , 1972), to revocation of a license as against denial of one, Ruffalo, 390 U.S. 544 (1964). In the instant case, Dr. Lary hired staff, rented office space, purchased supplies, and expended his time treating Medicare patients. Had the government denied payment to Dr. Lary in the first place, Dr. Lary could have rearranged his professional affairs by refusing to provide services to Medicare patients and by seeking alternate employment (such as treating only non-Medicare patients or by taking a salaried position). It is patently unfair of the government to reap the benefits of Dr. Lary's year of services to government beneficiaries, approve the services and pay the going legal rate for those services while they were being delivered, and then to retroactively disallow and recoup all the payments after the services have already been rendered. Even if, for the sake of argument, it may have been permissible for Medicare to deny payment to Dr. Lary in the first place because of his refusal to submit his confidential medical records to the carrier or because of his failure to create and maintain medical records satisfactory to the whims of an employee of Blue Cross Blue Shield of Alabama, it is never-the-less impermissible for the government to seize those payments long after they were paid without making a greater showing than would have been required to sustain a pre-payment denial. In the case of post-payment disallowance and recoupment, Dr. Lary had no opportunity to seek alternate income for that year of his practice. In the case of pre-payment denial, Dr. Lary would at least have quickly learned that he was not being paid for these services, allowing him time to seek alternate income before much of his year's effort and ordinary practice expenses had been expended on Medicare beneficiaries for naught.

Moreover, the government's actions in attempting to impose a record-keeping requirement on physicians are not in compliance with 42 U.S.C. Sec. 1395, which prohibits to the government any authority to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. But, in the instant case, the government has imposed a control over the practice of medicine by imposing the illegal requirements that (i) physicians create and maintain medical records of all patient encounters and (ii) that these records meet the record-keeping standards (whatever such standards are) imposed by the various Medicare carriers. If physicians are compelled to keep medical records which meet Medicare carrier's specifications (specifications which are unpublished and which apparently vary from carrier to carrier and even from auditor to auditor within a single carrier), then the the government has exercised such prohibited control over the manner in which medical services are provided.

THRESHOLD ISSUE OF 60 DAY TIME LIMIT

The Appeals Council relies upon well established rule about presumption of timely delivery of mail to hold that Dr. Lary's appeal was untimely filed. But this presumption requires sworn affidavit or testimony as to circumstances of mailing so as to permit inference of timely receipt. Where such sworn evidence is present, presumption is allowed.[5] Where such sworn evidence is lacking, presumption is not allowed.[6]

McKentry v. Sec. HHS, 655 F.2d 721, 724 (CA6 1981) is case similar to this case. There the Court of Appeals noted that the Secretary of HHS relied upon the presumption of delivery of mail to dismiss appeal. In refusing to permit such a presumption from the properly addressed and dated Notice of Reconsideration, the court noted that, "We find no evidence in the record that the notice was ever mailed to the appellant. The presence of

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5 In re East coast Brokers and Packers, Inc., 961 F.2d 1543, 1545 (CA11 1992), Peel v. Sec. HHS, 793 F.2d 1293, Old Ben Coal Co. v. Luker, 826 F.2d 688.

6 Leasing Assoc. Inc. v. Slaughter & Sons, Inc. 450 F.2d 174, 178 (CA8 1971), U.S. v. Burks, 867 F.2d 795, U.S. v. Srulowitz, 785 F.2d 382, Vogelsang v. Patterson, 904 F.2d 427.

a piece of paper in the Department's file is not necessarily proof of mailing. Atteberry v. Finch, 424 F.2d 35."

In Bartholomie v. Heckler, 597 F. Supp. 1113 (N.D.N.Y. 1984), notice dated September 25, 1980 was received by the claimant a few days later. Claimant's attorney, however, did not receive a copy of the notice until he inquired about his client's case almost three months later. Bartholomie's attorney received a copy of the Secretary's decision from the Social Security Administration more than four months after the decision date, and fifty-five days later filed suit in the district court. Even though suit was not filed until six months after Bartholomie received his 60-day notice, the district court refused to dismiss for untimely filing. In refusing to dismiss, the court relied upon the Secretary's failure to follow regulation providing that a copy of administrative decisions be sent to claimant's attorney.

20 C.F.R. Secs. 404.1705 allows a claimant to appoint an attorney as his representative. The Social Security Administration must, under 20 C.F.R. Sec. 404.1707, recognize claimant's attorney as his representative if both the claimant and the attorney file the proper notice, and the Secretary is required to send notice to a claimant's attorney under 20 C.F.R. Sec. 404.1715.

The two Appeals Council decisions [Appendix C(1) and C(2)] provide a good example as to reason courts have (with this case, apparently, being the only exception on record) insisted upon requirement of sworn affidavit or sworn testimony as to actual dates of mailing or of usual office procedures concerning mailing before permitting inference of timely delivery. To rely upon lesser evidence that sworn affidavit is to invite error. In this case, the two Appeals Council findings about mailing dates contradict each other, and thus both findings cannot possibly be correct. Both ALJ decisions were dated March 26 and were mailed in same envelope. And yet, the Appeals Council decided, based on its "computer records," that one decision was "mailed" April 20 (and received by April 25) while other decision was "issued" on March 26 (and received by March 31). Indeed, one of the ALJ decisions shows April 20 date stamp on its first page, while other shows no date stamp on its first page (implying that date of mailing is unknown). Clearly, fact of one envelope containing both March 26 decisions cannot square with Appeals Council findings that one

arrived before April 1 and other arrived after April 20. And even if ALJ had mailed the two decisions in two separate envelopes, one would expect normal office practices to result in both decisions being mailed simultaneously. Yet, relying upon alleged SSA computer records (a print-out of even which the government did not introduce into the hearing record), the respondent asks the court to accept Appeals Council's findings that both March 26 decisions were treated so differently. One was allegedly "issued" (mailed?) on March 26, while its companion decision was allegedly not mailed until April 20, almost three weeks later. In order for those events to have happened the way the Appeals Council alleges, the ALJ's office's practices with respect to mailing of ALJ decisions must be disorganized indeed.

Since there is no sworn evidence in file relating to date of mailing of ALJ decisions, government is not entitled to presumption of timely delivery to Dr. Lary personally. Even if timely delivery to Dr. Lary had occurred and had been proved, government still may not dismiss Dr. Lary's Appeals Council appeal for reason of untimely filed, since his attorney, in violation of 20 C.F.R. Sec. 404.1715, was never served with ALJ any notice at all, with result that 60 day statute of limitations is tolled until date claimant's attorney is served.

SUMMARY

Appeals Council dismissal was incorrect for two reasons, (i) it relies upon presumption that Dr. Lary received ALJ decisions within five days of March 26 without meeting well established requirement for presence of sworn testimony or affidavit of mailing, which is needed to sustain presumption, and (ii) it failed to honor regulations requiring tolling of 60 day statute of limitations until Dr. Lary's attorney receives copy of ALJ decisions, an event which has not yet occurred.

Constitution, as well as long established law predating Constitution, recognize right and duty of physicians to keep medical records confidential. Paperwork Reduction Act and Medicare regulations limit government's access to medical information to only the procedure code numbers and diagnostic code numbers found on Medicare HCFA-1500 claims forms. Government carrier's "determination" that Dr. Lary was subject to "overpayment refund" because of his refusal to copy and disclose his patient's confidential medical

records is erroneous determination, and should be overturned. Government's position that Medicare carrier may prescribe the contents of physician's medical records (over and above the requirement to supply procedure code and diagnostic code numbers) violates Constitution, Social Security Act, Paperwork Reduction Act, and case law.

CONCLUSION

The petitioner respectfully requests that certiorari be granted.

Respectfully submitted,

JOHN H. LARY, JR., M.D.
Petitioner Pro Se
600 St. Clair Street S.W.
Suite 12B
Huntsville, Alabama 35801
(205)533-1510

APPENDIX A

[DO NOT PUBLISH]

IN THE UNITED STATES
COURT OF APPEALS FOR
THE ELEVENTH CIRCUIT

No. 95-6839
Non-Argument Calendar

D.C. Docket No.
5:93-CV-2412-SLB

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
SEP 16 1996

MIGUEL J. CORTEZ
CLERK

JOHN H. LARY, JR., Dr.,
Plaintiff-Appellant,

versus

SHIRLEY S. CHATER,
Commissioner of Social Security; SECRETARY
OF HEALTH AND HUMAN SERVICES
Defendants-Appellants

Appeal from the United States District Court
for the Northern District of Alabama

(September 16, 1996)
Before KRAVITCH, BLACK and CARNER, Circuit Judges

PER CURIAM:

Appellant John Lary, Jr., a physician who receives supplementary Medicare insurance payments for his medical services, appeals the district court's order affirming the Secretary's determination that Dr. Lary was overpaid. The district court found meritless Lary's arguments that: his due process rights were violated because "the ALJ refused to admit into evidence certain evidence and denied [Lary's] pre-hearing discovery requests" ; Blue Cross bulletins, "periodic publications," and "payment guidelines" did not comply with the APA's notice and comment requirements; and the PRA placed no duty upon him to respond to requests to document his billing.

Upon the review of the file, Lary's due process claims and arguments regarding the Administrative Procedure Act (APA), 5 U.S.C. SS 706, and the Paperwork Reduction Act (PRA), 44 U.S.C. SS 3501 et seq., are without merit. In addition, Lary has waived the other arguments he raises on appeal.

AFFIRMED

APPENDIX B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
NORTHEASTERN DIVISION

JOHN H. LARY, JR., M.D.,

Plaintiff,

v. CASE NO.
CV 93-B-2412-NE

SECRETARY OF HEALTH AND
HUMAN SERVICES

Defendant

Entered
Sept. 28, 1995

MEMORANDUM OPINION

Currently before the court is the motion of the defendant, Secretary of Health and Human Services, ("Secretary"), to dismiss or, in the alternative, for summary judgment, filed on December 22, 1994. After reviewing the records, the submissions of the parties, and the relevant law, the court is of the opinion that the motion to dismiss is due to be denied and the motion for summary judgment is due to be granted.

The case arises out of two disputes between the plaintiff and Blue Cross and Blue Shield of Alabama concerning alleged overpayment for services rendered to Medicare beneficiaries. These disputes were docketed in the Social Security Administration's Office of Hearings and Appeals as Docket Number 000-49-0156 and Docket Number 000-40-1076. The record and transcript dealing with Docket No. 000-49-0156 will be referenced as R. 1 and TR.1; the record and transcript dealing with Docket No. 000-40-1076 will be referenced R. 2 and Tr. 2.

Docket No. 000-49-0156 dealt with a dispute over whether plaintiff was overpaid by $508.57 for medical services provided to Medicare Beneficiaries between January and June of 1987. The ALJ decided that plaintiff had been overpaid by $508.57, that plaintiff was not without fault in causing or accepting the overpayment, and therefore that recovery of the overpayment could not be waived. (R. 1 at 19).

Docket No. 000-40-1076 involved a dispute over whether plaintiff was overpaid by $5,616.22 for medical services provided to Medicare beneficiaries between October 1, 1988 and September 30, 1989. The ALJ reduced the overpayment amount by $999.79 and further concluded that because plaintiff was not without fault in causing or accepting the overpayment, recovery of the remaining overpayment ($4,616.43), could not be waived. (R. 2 at 21).

Docket No. 000-49-0156

Plaintiff is a specialist in internal medicine who practices in Huntsville, Alabama (R.1 at 20). In a letter dated August 31, 1988, the Medicare carrier, Blue Cross and Blue Shield of Alabama, informed plaintiff that it had conducted a review of Medicare claims covering the dates of October 1, 1986 through September 30, 1987. (R. 1 at 20, 147). As a result of the review, the carrier determined that plaintiff had billed the carrier for services that were not covered by Medicare. (R.1 at 147). The carrier identified an overpayment amount of $1,421.09 and requested that plaintiff refund this amount to the carrier. *Id.*. In a letter dated September 27, 1988, plaintiff enclosed two checks, one for $161.88[1] and the other for $1,19.21,[2] totaling $1.421.09. (R.1 at 154).

Plaintiff requested a carrier Fair Hearing on October 23, 1988. (R. 1 at 21, 168). The hearing occurred by telephone on January 4, 1989. (R. 1 at 223). The hearing involved two separate claims, one involved fifty-six beneficiaries, the other involve fifty beneficiaries. (R. 1 at 223). On January 20, 1989, the Hearing Officer rendered a decision and upheld the carrier's determination of overpayment.[3] (R. 1 at 21, 113-32).

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[1] Plaintiff indicated that the check for $616.88 was reimbursement for duplicate payment for services rendered to F. Taylor. (R.1 at 154).

[2] Plaintiff states that the check for $1,259.21 was reimbursement for payments to plaintiff for charges "performed for services unrelated to surgery rendered on the same day as [plaintiff] performed outpatient surgery." (R.1 at 154).

[3] The Hearing Officer reversed the carrier regarding payment on control number 800783532, procedure 81005 for Ella M. Williams (R.1 at 230).

Plaintiff appealed the decision of the Hearing Officer and requested a hearing before an ALJ in a letter dated February 2, 1989 (R. 1 at 233). The ALJ indicated that it could not consider claims for services provided prior to that date. (R. 1 at 20). The ALJ determined that claims for twenty-three beneficiaries remained and that the overpayment amount in dispute for services provided after January 1, 1987 was $508.57. *Id.* The ALJ aggregated the twenty-three claims, pursuant to section 1869(b)(2)(B), after finding that they contained "common issues of fact an law." *Id.* The ALJ then determined that he had jurisdiction to hear the appeal as the $500.00 in controversy requirement was met. *Id.* The hearing before the ALJ occurred on February 20, 1992 and the ALJ entered a decision on March 16, 1992 finding that plaintiff was overpaid $508.57 by the Medicare carrier for services provided between January 28, 1987 and June 9, 1987. (R. 1 at 24).

In a letter dated July 22, 1992, plaintiff requested that the Appeals Council review the decision of the ALJ (R.1 at 14). On August 20, 1993, the Office of Hearings and Appeals of the Department of Health and Human Services notified plaintiff that he failed to timely file his request for review and that the Appeals Council would dismiss his request for review if plaintiff failed to demonstrate "good cause" for late filing (R.1 at 10).

Plaintiff submitted a sworn affidavit to the Office of Hearings and Appeals dated August 26, 1993. (R.1 at 6). Plaintiff indicated that he did not receive timely notice of the ALJ's decision on March 26, 1992 and that he had filed a timely request for review. (R. 1 at 8). The Appeals Council concluded that plaintiff failed to demonstrate good cause to extend the time for filing an appeal and denied Plaintiff's request for review. (R. 1 at 4).

Docket No. 000-40-1076

In a letter dated January 8, 1990, the Medicare carrier, Blue Cross and Blue Shield of Alabama, informed plaintiff that it would conduct a post payment review of claims that plaintiff submitted to the carrier for services rendered to Medicare beneficiaries between October 1, 1988 and September 30, 1989. (R. 2 at 22). In conjunction with the review, the carrier requested that plaintiff submit a random sample of the medical records of his

patients who were beneficiaries of the Medicare carrier.[4] *Id.*

Plaintiff reported that he would not comply with the carrier's request to supply the relevant records because compliance would be unduly burdensome. *Id.* Consequently, the carrier, based on a statistical random sample, projected an overpayment to plaintiff of $28,729.30 and requested that plaintiff reimburse the carrier for the amount of the overpayment. (R. 2 at 22).

On July 2. 1990, the carrier Utilization Review Committee conducted a hearing. At this hearing plaintiff submitted the medical records previously requested by the carrier. After reviewing the records, the carrier Utilization Review Committee recalculated the carrier's overpayment and determined the overpayment to be $5,616.22. (R. 2 at 22). On September 5, 1990, the plaintiff filed a request for a hearing before an ALJ to review the carrier Utilization Review Committee's decision. (R. 2 at 21). On March 26, 1992, the ALJ entered a decision finding that plaintiff was overpaid $4616.43 by the Medicare carrier and reducing the overpayment calculated by the carrier Utilization Review Committee by $999.79. (R. 2 at 21).

In a letter dated July 22, 1992, plaintiff requested that the Appeals Council review the decision of the ALJ. (R. 2 at 17). On December 6, 1993, the Office of Hearings and Appeals of HHS notified the plaintiff that he failed to timely file his request for review and that the Appeals Council would dismiss the plaintiff's request for review unless the plaintiff demonstrated "good cause" for the late filing. (R.2 at 9).

Plaintiff responded to the December 6, 1993 letter by submitting a sworn affidavit to the Office of Hearings and Appeals, dated December 13, 1993. Plaintiff testified that he did not receive timely notification of the March 26, 1992 ALJ's decision and that he had filed a timely request for review. (R. 2 at 7). Also, in a letter dated December 12, 1993, the plaintiff attributed the long delay

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[4] Under the Medicare Act, a physician will not be paid for services "unless there has been furnished such information as may be necessary in order to determine the amounts due..." 42 U.S.C. SS 13951(e) (1988). Beneficiaries are reimbursed on the basis of the amounts charged, subject to the carrier's responsibility to establish the appropriate "reasonable charge." 42 U.S.C. SS 13951(a)(1) (1988); 42 C.F.R. SS 405.501 et seq. (1994)

between the date of the ALJ decision and the date that he received notice to "some sort of mails snafu." (R. 2 at 6). The Appeals Council concluded that the plaintiff's affidavit failed to establish the requisite good cause necessary to extend the time for filing an appeal and dismissed the plaintiff's request for review. (R. 2 at 3-4).

MOTION TO DISMISS STANDARD

Under FED. R CIV. P. 12(b)(1), a party may move the court to dismiss a case if the court lacks jurisdiction over the subject matter of the case. Attacks on subject matter jurisdiction over the subject matter of the case. Attacks on subject matter jurisdiction under FED. R. CIV. P. 12(b)(1) occur in two forms: facial attacks and factual attacks. *Lawrence v. Dunbar*, 919 F.2d 1525, 1529 (11th Cir. 1990); *Eaton v. Dorchester Dev., Inc.*, 692 F2d 727, 731 (11th Cir. 1982).

Facial attacks on the complaint require the court to determine whether the plaintiff has alleged, with sufficiency, a basis of subject matter jurisdiction. The allegations in the plaintiff's complaint are presumed to be true for the purposes of the 12(b)(1) motion. *Lawrence*, 919 F.2d at 1529 (citations omitted). Appellate review of facial attacks is limited to the issue of whether or not the complaint sufficiently alleges that jurisdiction is proper, assuming that all allegations in the complaint are true. *Eaton*, 692 F.2d at 732 (citing *Paterson v. Weinberger*, 644 F.2d 521, 523 (5th Cir. 1981)).

Factual attacks "'challenge the existence of subject matter jurisdiction in fact, irrespective of the pleadings, and matters outside the pleadings, such as testimony and affidavits, are considered.'" *Lawrence*, 919 F.2d at 1529 (citation omitted). Therefore, when the jurisdiction attack is factual, the plaintiff is not afforded the safeguards and presumptions of truthfulness that exist with facial attacks to jurisdiction:

> [T]here is substantial authority that the trial court is free to weigh the evidence and satisfy itself as to the existence of its power to hear the case. In short, no presumptive truthfulness attaches to plaintiff's allegations, and the existence of disputed material facts will not preclude the trial court from evaluating for itself the merits of jurisdictional claims.

Lawrence, 919 F.2d at 1529 (citation omitted).

DISCUSSION

Subject Matter Jurisdiction

A physician, such as the plaintiff, who is dissatisfied with a payment determination by a carrier may obtain administrative and judicial review. 42 U.S.C. SS 1395ff(b)(1)(B) (1988). The carrier's Fair Hearing officer is the first level of review. 53 Fed. Reg. 20,023, 20,024 (1988). The hearing officer's decision may be appealed to an HHS administrative law judge with additional administrative review available before the HHS Appeals Council. 20 C.F.R. SS 404.929 (1994); 404.967 (1994). Under 20 C.F.R. SS 404.971 (1994), the HHS Appeals Council will dismiss a party's request for review if the request is not filed within the stated period of time, which is generally 60 days after claimant receives notice of the hearing decision. The decision of the Appeals Council to dismiss a request for review is "binding and not subject to further review." 20C.F.R. SS 404.972 (1994). 'Final" administrative decisions are appealable to the appropriate federal district court under 42 7.S.C. SS 405 (g).[5]

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5 Any individual after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. (emphasis added).
42 U.S.C. SS 405 (g) (1988). The Supreme Court has stated that a "'final decision'" is "a statutorily specified jurisdictional prerequisite" under 42 U.S.C. SS 405 (g). *Weinberger v. Salfi*, 422 U.S. 749, 766 (1975).
The date of receipt of a decision is presumed to be five days from the mailing date on the notice. *See* 20 C.F.R. SS 404.901 (1994) (creating a rebuttable presumption of receipt within five days from the mailing date on this notice).

The defendant raises a factual attack on this court's authority to adjudicate the plaintiff's claims based on a lack of subject matter jurisdiction. Defendant asserts that the plaintiff aborted the administrative review process by his untimely requests for Appeal Council review, and is therefore ineligible to obtain judicial review under the Medicare Act.[6]

It appears that the 11th Circuit stands alone in holding that a district court has jurisdiction to review an Appeals Council decision denying an untimely appeal from an ALJ hearing. *See Bloodsworth v. Heckler* 703 F.2d 1233, 1239 (11th Cir. 1983); *see also Stone v. Heckler*, 778 F.2d 645, 648 (11th Cir. 1985)(*Bloodsworth* still binding in 11th Circuit).[7] The other courts of appeal which have addressed this issue have held that the Appeals Council may dismiss untimely requests for review of ALJ decisions and such dismissals are not reviewable by district courts because they are not "final decisions." *See Bacon V. Sullivan*, 969 F.2d 1517, 1520-21 (3rd Cir. 1992); *Matlock v. Sullivan*, 908 F.2d 492, 494 (9th Cir. 1990); *Turner v. Bowen*, 862 F.2d 708, 709-710 (8th Cir. 1988); *Harper v. Heckler*, 799 F.2d 131. 133 (4th Cir. 1986); *Dietsch v. Schweiker*, 700 F.2d 865, 867 (2d Cir. 1983); *Watters v. Harris*, 656 F.2d 234, 238-39 (7th Cir. 1980).

Although the decision on which *Bloodsworth* primarily relied, *Langford v. Flemming*, 276 F.2d 215 (5th Cir. 1960), has now been overruled by *Harper v. Bowen*, 813 F.2d at 743, *Bloodsworth* is still the law of this circuit.[8] Thus, the decision of the Appeals Council

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6 42 U.S.C. SS 405(g) (1988) establishes the procedures for obtaining administrative and judicial review of all Part B challenges to the Medicare Act. 42 U.S.C. 405(h) (1988) prohibits federal court review of administrative decisions except as provided in 42 U.S.C. SS 405(g).

7 Defendant's argument that *Stone* limits the *Bloodsworth* holding is incorrect.

8 *Bloodsworth*, relying on *Langford*, permitted judicial review of *denials of requests for review* by the Appeals Council. However, because of the unique procedural history in *Bloodsworth*, the court reviewed the underlying decision of the ALJ. The *Langford* court merely considered whether the Appeals Council's decision declining to review the ALJ's decision was an abuse of discretion. This court will not review the underlying decisions of the ALJ to see if they are

denying plaintiff's request for review was a "final decision" according to the *Bloodsworth* analysis; therefore, 42 U.S.C. SS 405 (g) applies and this court has subject matter jurisdiction to review the denial by the Appeals Council of plaintiff's request to review the two ALJ decisions at issue.

The Appeals Court Decision

As noted, the court in *Bloodsworth* held that the denial of a request for review is final and subject to judicial review. The court will not address plaintiff's argument that the Appeals Council erred when it declined to grant the plaintiff a "good cause" exception to the prescribed time deadline for filing a request for review with the Appeals Council. The ALJ entered the two decisions at issue on March 26, 1992. (R.1 at 24, R.2 at 28). The ALJ mailed a copy of the decisions to plaintiff on March 26, 1992, and plaintiff's request for review was filed on July 28, 1991, more than thirty days after the sixty-day deadline for appealing an ALJ decision to the Appeals Council. (R. 1 at 17; R.2 at 20). After considering plaintiff's explanation for the delay, the Council found that plaintiff failed to show good cause to extend the time for the plaintiff to file his appeal and denied the plaintiff's request for review.

The standard for demonstrating "good cause" under the Social Security Act is set forth in 20 C.F.R. SS 404.911.[9] While this court has jurisdiction to review the decision of the Appeals

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supported by substantial evidence, as the court perceives such a review to be beyond the specific holding in *Bloodsworth*

[9] 20 C.F.R. SS 404.911 (1994) provides:

Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you had good cause for missing a deadline to request review we consider--

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or

Council to deny a review, the court will only reverse the Appeals Council's decision if the court determines that the Council "has abused its discretion by acting arbitrarily and capriciously." *Western Medical Enter., Inc. v. Heckler*, 783 F.2d 1376, 1381 (9th Cir. 1985). [10] "Under this narrow standing of review, a court lacks the power to substitute its judgment for that of the

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knowing about the need to file a timely request for review.
(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:
(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.
(2) There was a death or serious illness in your immediate family.
(3) Important records were destroyed or damaged by fire or other accidental cause
(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.
(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit (6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.
(7) You did not receive notice of the determination or decision.
(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.
(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which shows that you could not have known of the need to file timely, or which prevented you from filing timely.

[10] *Western Medical Enterprises* involved a good cause determination by the Medicare system's Provider Review Board. This Board is the Medicare Part A administrative equivalent of the ALJ which hears Medicare Part B and Social Security Cases.

administrative agency. If the agency's findings are supported by substantial evidence and are
not arbitrary or capricious, the reviewing court cannot reverse the findings of the agency on the basis that it would have decided the case differently." *Home Health Services of the U>S> v. Schweiker*, 683 F.2d 353, 356-57 (11th Cir. 1982).

The court finds that the Appeals Council did not arbitrarily or capriciously deny plaintiff's request for review based on a failure by the plaintiff to demonstrate good cause for the delay in filing his request for review. The plaintiff submitted a letter, dated December 12, 1993 a sworn affidavit, dated December 13, 1994 in which he states that there was a long delay between the date of the ALJ decision and the date that the post office delivered the notice of the decision to the plaintiff. Additionally, the plaintiff states, in both the letter and the sworn affidavit, that he filed his request for Appeals Council review well within sixty days of the date that he actually received notice of the ALJ decision. The Appeals Council considered both the plaintiff's above mentioned letter and sworn affidavit and determined that the plaintiff failed to demonstrate good cause for his late filing. The Appeals Council noted in its Order of Appeals Council that he plaintiff's affidavit did not specify the date the ALJ's decision was received nor did the plaintiff submit a postmarked envelope or any other evidence that would indicate the date that the notice was delivered. The Council determined that, absent any evidence of the date the plaintiff received notice, the plaintiff's affidavit failed to establish a credible explanation for the untimely filing.

The Appeals Council considered the plaintiff's request for an extension and plaintiff's evidence in support of his request. The Appeals Council concluded that the reasons advanced by the plaintiff did not constitute good cause for the late filing pursuant to 20 C.F.R. SS 404.911. This court finds no abuse of discretion by the Appeals Council. Thus, the decision of the Appeals Council is due to be affirmed.

Due Process Claim

Plaintiff also alleges that he was denied due process by certain of the ALJ's decisions. According to the plaintiff, the due process deprivations occurred when the ALJ refused to admit into evidence certain

evidence[11] and denied plaintiff's pre-hearing discovery requests. [12] Additionally, plaintiff alleges that the notice of the ALJ Hearing was defective so as to deny him due process.

"Section 405(g) provides for judicial review of decisions by the Secretary adverse to a claimant . . . The statute limits factual review to determining whether the Secretary's findings are supported by substantial evidence." *Hummel v. Heckler*,736 F.2d 91, 93 (3rd Cir. 1984). 41 U.S.C. SS 405(g) does not have the effect of applying the Federal Rules of Civil Procedure to the administrative review provisions of the Social Security Act. *Id.* "Neither the Social Security Act nor the Administrative Procedure Act provide for prehearing discovery at the administrative level; and none is normally available." *Small v. Sullivan*, 820 F. Supp. 1098, 1106 (S.D. Ill. 1992) (citing *Hummel*, 736 F2d at 91).

The decision of the ALJ denying plaintiff's request to subpoena the Medicare Carrier's Manual did not violate plaintiff's due process rights. Similarly, the ALJ did not deny plaintiff due process by refusing to allow testimony regarding the plaintiff's coding practices in prior unrelated Medicare audits.

Defendant's motion for summary judgment on plaintiff's due process claim is due to be granted.

Administrative Procedure Act Claim

The plaintiff asserts that "'Carrier Bulletins'" and "'periodic publications issued by the carrier'" and "'payment guidelines'" issued by the carrier fail to comply with the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. SS 553(b)(3)(A) (1994). This assertion lacks merit.

The APA's publication, notice, and comment requirements apply to "substantive rules of general application adopted a authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency" 5 U.S.C. SS 552(a)(1)(D) (1994). Section 553(b) of the APA requires a general notice of proposed rules be published in the Federal Register subject to certain exceptions. 5 U.S.C. SS 553(b)(1994).

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[11] Plaintiff sought to introduce into evidence testimony about an earlier, unrelated Medicare review concerning claim coding.

[12] The ALJ denied plaintiff's request to subpoena the Medicare Carrier's manual.

The APA exempts from its notice and comment requirements "interpretive rules, general statements of policy, or rules of agency organization, procedure or practice." 5 U.S.C. SS 553(b)(3)(A) (1994). The Carrier's Bulletin, periodic publications and the payment guidelines come within this exception to the APA reporting requirement. "Agency manuals, guidelines, and memoranda are interpretive rules not subject to the APA." *Mile High Therapy enters, Inc., v. Bowen.* 735 F. Supp. 984. 986 (D.Colo. 1988) (holding that both the Medicare Carrier's Manual and the Health Care Financing Administration's ruling explaining the use of statistical sampling methods were exempt from APA publication requirements; *accord, Chaves County Home Health Serv., Inc. v. Sullivan* , 732 F. Supp. 188, 191 (D.D.C. 1990),*aff'd* , 931 F.2d 914, 289 (D.C. Cir. 1991). In Mile *High Therapy Mile High Therapy Centers, Inc.* , the court held that the Medicare Carrier's Manual was a mere interpretation of all existing statute and therefore not subject to the notice and comment requirement of the APA. *Mild High Therapy Centers,, Inc.* 735 F. Supp. at 986;*see also Schupak v. Califano,* 454 F. Supp. 105, 115-16 (E.D.N.Y. 1978) (stating that Medicare fiscal intermediary's letters seeking cost information from health care providers are exempt from the APA notice and comment requirements).

"In practice, the courts have consistently required that agencies publish their rules and policy statements only if they constitute a change from existing law, policy or practice." *Knutzen v. Eben Ezer Lutheran Hous. Ctr.* 815 F2d 1343, 1351 (10th Cir. 1987). There is no evidence indicating that either the Carrier's Bulletin, the periodic publications, or the payment guidelines create changes in existing law, policy or practice. Therefore, these documents are exempt under 5 U.S.C. SS 553(b)(3)(A) from the APA's notice and comment requirement.

Accordingly, defendant's motion for summary judgment on plaintiff's claim of violation of the APA is due to be granted.

The Paperwork Reduction Act Claim

The plaintiff alleges that pursuant to the Paperwork Reduction Act, 44 U.S.C. SS 3501 et seq. (1988), he had no duty to respond to me Secretary's or the carrier's request for documentation in the case docketed as 000-40-1076. Plaintiff asserts that unless the requests

contained an OMB control number he had no duty to respond.

The Act states that "no person shall be subject to any penalty for failing to maintain or provide information to any agency if the information collection request involved was made after December 31, 1981, and does not display a current control number assigned by the Director, or fails to state that such request is not subject to this chapter." 44 U.S.C. SS 3512(a)(1) (1988). The Act prohibits an agency from imposing a penalty on an individual who fails to provide information where the request for information did not comply with the Act.

Plaintiff was not penalized for his initial failure to provide the records requested by the carrier. The carrier, based on a statistical random sample, projected an overpayment amount for the plaintiff after the plaintiff refused to make available to the Medicare carrier documents regarding Medicare beneficiaries that the plaintiff had treated. The use of statistical sampling methods to calculate the amounts of overpayment, alone and without any evidence of misconduct, does not constitute a penalty. *See Mile High Therapy Centers, Inc.*, 735 F. Supp. at 986 (holding that HHS has the statutory authority to use statistical sampling to determine overpayments of Medicare reimbursements under circumstances where a case by case review is not feasible). "The clear majority of those few courts having confronted statistical sampling in analogous contexts, while acknowledging its potential for unfairness in the abstract in particular cases, have nevertheless approved its use." *Chaves County Home Health*, 732 F. Supp. at 189.

In a Seventh Circuit opinion, the court held that "[t]he use of statistical samples has been recognized as a valid basis for findings of fact in the context of Medicaid reimbursement." *Illinois Physician's Union v. Miller*, 675 F.2d 151, 156 (7th Cir. 1982). The court further stated "that the use of sampling and extrapolation is proper provided there is an opportunity to rebut the initial determination of overpayment." *Id.* Here plaintiff had an opportunity to rebut the initial determination of overpayment at a carrier fair hearing which was conducted on July 2, 1990. As a result of that hearing, the carrier Utilization Review Committee recalculated the overpayment and reduced it from $28,729.30 to $5,616.22. Ultimately, the amount of the overpayment was reduced to $4616.43.

HHS has authority to make projections concerning overpayments using a random sampling method when the underlying circumstances do not permit a case by case review. The use of a random sample does not constitute a "penalty" under the Act.

CONCLUSION

Defendant has failed to establish that this court lacks subject matter jurisdiction regarding this case. Accordingly, defendant's motion to dismiss is due to be denied.

Plaintiff has raised no genuine issues of material fact regarding his claims of due process violations, violation of the Administrative Procedure Act, or violation of the Paperwork Reduction Act. The court further finds that the decision of the Appeals Council denying plaintiff's request for review as not arbitrary, capricious, or an abuse of discretion. Accordingly, defendant's motion for summary judgment is due to be granted.

An order granting defendant's motion for summary judgment will be entered contemporaneously herewith.

DONE this 27th day of September, 1995.

s/ Sharon Lovelace Blackburn
SHARON LOVELACE BLACKBURN
United States District Judge.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
NORTHEASTERN DIVISION

JOHN H. LARY, JR., M.D.,

Plaintiff,

v.

CASE NO.
CV 93-B-2412-NE

SECRETARY OF HEALTH AND
HUMAN SERVICES

Defendant

Entered
Sept. 28, 1995

ORDER

In accordance with the Memorandum Opinion entered contemporaneously herewith, it is hereby ORDERED that defendant's Motion to Dismiss is DENIED and that defendant's Motion for Summary Judgment is GRANTED, as no genuine issue of material fact exists herein and defendant is entitled to judgment as a matter of law.

DONE this 27th day of September, 1995.

s/ Sharon Lovelace Blackburn
SHARON LOVELACE BLACKBURN
United States District Judge

APPENDIX C(1)

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

ORDER OF APPEALS COUNCIL

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	Supplementary Medical Insurance Benefits
Multiple (Beneficiary)	Multiple (HICN)
Blue Cross/Blue Shield of Alabama (Carrier)	000-49-0156 (Docket Number)

This case is before the Appeals Council on the appellant's request for review of the Administrative Law Judge's decision issued on March 26, 1992. The request for review filed on July 28, 1992 was not filed within 60 days from the date notice of the decision was received as required by Social Security Administration regulations (20 CFR 404.968(a)). The date of receipt of the notice is presumed to be five (5) days after the date of such notice unless a reasonable showing to the contrary is made.

The regulations provide that the Appeals Council may dismiss a request for review where the appellant has failed to file the request within the stated period of time, and the time for filing has not been extended (20 CFR 404.971). The time period will be extended if good cause is shown for missing the deadline (20 CFR 404.968(b)).

On August 20, 1993, the Appeals Council notified the appellant that it proposed to dismiss the request for review absent an explanation as to why the request was not filed within the prescribed 60-day limit. In response, the appellant submitted an affidavit stating that he did not receive timely notification of the Administrative Law Judge's decision dated March 26, 1992, and his request for review was filed within 60 days of his receipt of that

decision. However, Social Security Administration computer records reveal that the Administrative Law Judge's decision was issued on March 26, 1992 to the appellant's current address, and the request for review was filed more than 60 days late. The appellant's affidavit does not specify the date the Administrative Law Judge's decision was received, nor was the postmarked envelope or any other evidence submitted. Absent such evidence, there appears to be no basis to conclude that the Administrative Law Judge's decision was delayed by the U.S. Postal Service for over two months. Consequently, the Appeals Council concludes that the appellant's affidavit fails to establish a credible explanation for the untimely filing.

The Appeals Council, therefore finds that there is no good cause to extend the time for filing and, accordingly, dismisses the appellant's request for review. The administrative Law Judge's decision stands as the final decision of the Secretary.

Notice of this action is hereby given by mailing a copy to the appellant.

APPEALS COUNCIL

s/ Harry H. Barr
Harry H. Barr
Administrative Appeals Judge

Date: Oct 14, 1993

Appellant's Name and Address:
John H. Lary, Jr., M.D.
600 St. Clair Street, N. W.
Huntsville, AL 35801

APPENDIX C(2)

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

ORDER OF APPEALS COUNCIL

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	Supplementary Medical Insurance Benefits
Multiple (Beneficiary)	Multiple (HICN)
Blue Cross/Blue Shield of Alabama (Carrier)	000-40-1076 (Docket Number)

This case is before the Appeals Council on the appellant's request for review of the Administrative Law Judge's decision mailed on April 20, 1992. The request for review filed on July 28, 1992 was not filed within 60 days from the date notice of the decision was received as required by Social Security Administration regulations (20 CFR 404.968(a)). The date of receipt of the notice is presumed to be five (5) days after the date of such notice unless a reasonable showing to the contrary is made.

The regulations provide that the Appeals Council may dismiss a request for review where the appellant has failed to file the request within the stated period of time, and the time for filing has not been extended (20 CFR 404.971). The time period will be extended if good cause is shown for missing the deadline (20 CFR 404.968(b)).

On December 6, 1993, the Appeals Council notified the appellant that it proposed to dismiss the request for review absent an explanation as to why the request was not filed within the prescribed 60-day limit. In response, the appellant submitted an affidavit stating that he did not receive timely notification of the Administrative Law Judge's decision which was mailed on April 20, 1992, and his request for review was filed within 60 days of his

receipt of that decision. However, Social Security Administration computer records reveal that the Administrative Law Judge's decision was mailed on April 20, 1992 to the appellant's current address, and the request for review was filed more than 30 days late. The appellant's affidavit does not specify the date the Administrative Law Judge's decision was received, nor was the postmarked envelope or any other evidence submitted. Absent such evidence, there appears to be no basis to conclude that the Administrative Law Judge's decision was delayed by the U.S. Postal Service for over a month. Consequently, the Appeals Council concludes that the appellant's affidavit fails to establish a credible explanation for the untimely filing.

The Appeals Council, therefore finds that there is no good cause to extend the time for filing and, accordingly, dismisses the appellant's request for review. The administrative Law Judge's decision stands as the final decision of the Secretary.

Notice of this action is hereby given by mailing a copy to the appellant.

APPEALS COUNCIL

s/ Harry H. Barr
Harry H. Barr
Administrative Appeals Judge

Date: January 14, 1994

Appellant's Name and Address:
John H. Lary, Jr., M.D.
600 St. Clair Street, N. W.
Huntsville, AL 35801

cc:
HO, Arlington, VA (ALJ Jacobs)

APPENDIX D

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 95-6839
Non-Argument Calendar

FILED U.S COURT OF APPEALS
ELEVENTH CIRCUIT

D.C. Docket No.
5:93-CV-2412-SLB

NOV 25 1996
MIGUEL J. CORTEZ
CLERK

JOHN H. LARY, JR., Dr.,
Plaintiff-Appellant,

versus

SHIRLEY S. CHATER, Commissioner of Social Security;
SECRETARY OF HEALTH AND HUMAN SERVICES

Defendants-Appellants

On Appeal from the United States District Court for the Northern District of Alabama

Before KRAVITCH, BLACK and CARNER, Circuit Judges

PER CURIAM:

The petition(s) for rehearing filed by the appellant John H. Lary, Jr is denied.

ENTERED FOR THE COURT:

s/ Susan M. Black
Susan M. Black
UNITED STATES CIRCUIT JUDGE

APPENDIX E

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D. C. 20543

February 20, 1997

Mr. John H. Lary
600 St. Clair Street S.W.
Suite 12B
Huntsville, AL 35801

Re: John H. Lary
v. Shirley S. Chater, Commissioner of Social Security
Application No. A-593

Dear Mr. Lary:

The application for an extension of time within which to file a petition for a writ of certiorari in the above-entitled case has been presented to Justice Kennedy, who on February 20, 1997, extended the time to and including March 21, 1997.

This letter has been sent to these designated on the attached notification list.

Sincerely
WILLIAM K. SUTER, Clerk

By s/Gail B. Johnson
Gail B. Johnson
Assistant Clerk

APPENDIX F

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D.C. 20543

March 25, 1997

John H. Lary, Jr.
600 St. Clair Street S.W.
#12B
Huntsville, AL 35801

Re: John H. Lary, Jr. v. Chater, Cmnr. SSA, et al.

Dear Mr. Lary:

Returned are 39 of the 40 copies of a petition for a writ of certiorari in the above-entitled case postmarked on March 21, 1997 and received on March 24, 1997, which fails to comply with the Rules of this Court.

The page limit of a petition for a writ of certiorari is 30 pages. Rule 33.1(g).

The text of the petition and appendix must appear on both sides of the pages. Rule 33.1(b).

Rule 33.1(c) prohibits the use of spiral, plastic, metal or string bindings. Staples may be used, at least two, along the left margin covered with tape.

Kindly redo the petition and appendix so that it complies in all respects with the Rules of the Court and return it to this office promptly so that it may be docketed. Unless the petition is received by this office in corrected form within 60 days of the date of this letter, the petition will not be filed. Rule 14.5.

This office shall retain one copy of the petition and your check in the amount of $300.00 in expectation of receipt of a properly prepared petition.

Enclosed is a copy of the Rules of the Court and memorandum concerning the preparation of a petition.

Sincerely,
William K. Suter, Clerk
By: s/ Ruth Jones
Ruth Jones
(202)479-3022

Enclosures
cc: Solicitor General

APPENDIX G

MEDICARE
P.O. Box 995
450 Riverchase Parkway East
Birmingham, Alabama 35298

January 8, 1990

John H. Lary, Jr., M.D.
600 St. Clair Street, Suite 12-B
Huntsville, AL 35801-5020

CERTIFIED MAIL P 025 553 606

Dear Dr. Lary:

Blue Cross and Blue Shield of Alabama is the Medicare Carrier for all part B providers in the State. We are charged with the responsibility for conducting Postpayment Comprehensive Medical Reviews.

In order to better evaluate the services which you have performed, we request that you submit to us a copy of any office records you have which pertain to the services provided to the enclosed list of Medicare patients. These records should include lab, x-ray, EKG services, diagnostic procedures and any other medical care provided in your office. You may also submit any additional information which would assist our representatives in determining the medical necessity of services rendered to these Medicare patients.

Please furnish this information within fifteen (15) days of the receipt date of this letter. If there are denial determinations, upon completion of our review, you will be notified of our findings.

Please forward these records to the following:

Frances McMickle
Medicare Utilization Review/Medical Review
P. O. Box 13384
Birmingham, Alabama 35202-3384

Should you have any questions concerning this request, please contact me at (205) 988-2185.

Sincerely,

s/ Frances McMickle
Frances McMickle
Audit Technician
Medicare Utilization Review/Medical review

/fm

Enclosure

cc: Jeff Syphurs

APPENDIX H

MEDICARE
P.O. Box 995
450 Riverchase Parkway East
Birmingham, Alabama 35298

March 12, 1990

John H. Lary, Jr., M.D.
600 St. Clair Street, Suite 12-B
Huntsville, AL 35801-5020

CERTIFIED MAIL P979 126 505

Dear Dr. Lary:

We recently conducted a review of Medicare claims paid to you during the time period of October 1, 1988 through September 30, 1989. The claims for these services were reviewed for the purpose of validation.

In the course of reviewing the claims you submitted, it was determined that you were billing for services that were noncovered by Medicare. Enclosed are copies of our medical rationale for the services in question on each beneficiary included in this review. Our medical review identified an overpayment in the amount of $28,729.30. This is a projected overpayment amount based on a statistical random sample. No part of this amount should be billed to the beneficiaries since they are covered by Waiver of Liability.

As indicated above it has been determined that you have been overpaid $28,729.30. It is expected that you will remit the entire amount in one payment within 30 calendar days from the date of this letter. However, if you are unable to repay the amount within that time, we are authorized to consider repayment based on documented financial hardship. You should be aware that in accordance with Public Law 97-248, if repayment is not made within 30 days interest at the rate of 9% will accrue on the balance outstanding from the date of this letter. If you wish to claim financial hardship, you should complete the attached questionnaire and include it with your request for approval of an installment schedule. If compliance with the above is not acceptable

to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.

If repayment of the amount due in a lump sum or on an approved installment plan is not forthcoming, the Health Care Financing Administration may, at their option, forward the case to the Office of the Inspector General for consideration for suspension action.

Your refund check in the amount of $28,729.30 should be made payable to Blue Cross and Blue Shield of Alabama and forwarded to my attention. Enclosed is a self-addressed envelope for your convenience.

If you disagree with our findings, you have a right to a Fair Hearing if the overpayment amount exceeds $100.00 and we receive from you a written request within six months from the date of this letter. Your request must clearly state the type of hearing requested and your reason for disagreement.

Continuation of the inappropriate action discussed herein could result in your being exclude from participation in the Medicare Program in accordance with section 1128 (b) (6) of the Social Security Act.

If you have any questions concerning this decision, please contact me at (205) 988-2176.

Sincerely,

s/ Melissa J. Kerzic
Melissa J. Kerzic
Health Care Representative
Medicare Utilization Review/Medical Review

MJK/vo

Enclosures
cc: Normal Love
Lynda Northcutt
Jeff Syphurs
Ronnie Bollen
Alan Dane

REASONS FOR DISALLOWANCE OF MEDICARE PAYMENT
1. No medical records submitted for review.

Supreme Court, U.S.
FILED
JUL 21 1997
CLERK

No. 96-1849

In the Supreme Court of the United States

OCTOBER TERM, 1996

JOHN H. LARY, JR., PETITIONER

v.

SHIRLEY CHATER, COMMISSIONER OF SOCIAL SECURITY, AND DONNA SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

WALTER DELLINGER
Acting Solicitor General
FRANK W. HUNGER
Assistant Attorney General
ANTHONY J. STEINMEYER
KATHERINE S. GRUENHECK
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

40 pp

QUESTION PRESENTED

Whether the Secretary's Medicare Part B overpayment determination in this case comports with statutory and due process requirements.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 96-1849

JOHN H. LARY, JR., PETITIONER

v.

SHIRLEY CHATER, COMMISSIONER OF SOCIAL SECURITY, AND DONNA SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1) is unpublished, but the decision is noted at 98 F.3d 1353 (Table). The memorandum opinion and order of the district court (Pet. App. B1-B15) are also unreported.

JURISDICTION

The judgment of the court of appeals was entered on September 16, 1996. A petition for rehearing was denied on November 25, 1996. Pet. App. D1. On February 20, 1997, Justice Kennedy extended the time within which to file a petition for a writ of certiorari to and including March 21, 1997 (Pet. App. E1), and the

petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In 1965, the Medicare program was enacted as Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* Medicare has two components. Part A provides primarily hospital insurance, and Part B provides supplementary medical insurance benefits relating largely to physician services. This case involves only reimbursement of claims under Part B for services supplied by petitioner, a physician.

In administering Part B of the Medicare program, the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) acts through "carriers." 42 U.S.C. 1395u. As statutory agents for HCFA, those private entities, like Blue Cross and Blue Shield of Alabama in this case, perform a variety of functions, such as determining billing standards and reasonable charges for services. Medicare authorizes reimbursement for "reasonable and necessary" services only. 42 U.S.C. 1395y(a)(1)(A). In this regard, the carrier must monitor the actual charges to Medicare beneficiaries to determine whether, *inter alia*, the physician has billed in excess of the maximum allowable charge or billed for medically unnecessary services. 42 U.S.C. 1395u(j)(1) and (*l*).

When a physician files a request for a Medicare Part B payment, the carrier makes an initial evaluation of the claim. If the claim appears "reasonable" under applicable standards, the carrier determines the amount of benefits to be paid. 42 U.S.C. 1395*l*(a)(1); 42 C.F.R. 405.501 *et seq.* In determining whether a "reasonable charge" for physician ser-

vices has been billed, the carrier generally considers: (1) the actual charge; (2) the physician's customary charge; and (3) the prevailing charge in the locality for similar services. 42 C.F.R. 405.502; see generally 42 U.S.C. 1395u(b)(3). Post-payment audits by carriers are authorized as a check to ensure that only "reasonable and necessary" charges were paid. 42 U.S.C. 1395*l*(a)(1) and (e), 1395u(a); 42 C.F.R. 405.501 *et seq.* A Part B physician must supply whatever medical records the carrier deems necessary and appropriate in such an audit to establish the correctness of the payment made by Medicare. 42 U.S.C. 1395*l*(e). Retroactive corrective adjustments in payments may be made when the initial payment proves inadequate or excessive. 42 U.S.C. 1395x(v)(1)(A)(ii).

A beneficiary or physician who is dissatisfied with a payment determination may seek administrative and judicial review. 42 U.S.C. 1395ff(b). The first level of administrative review is a carrier fair hearing. 53 Fed. Reg. 20,023, 20,024 (1988). The hearing officer has authority to review and, if necessary, correct errors by the carrier in the implementation of the program, but is bound by HHS policies and guidelines. 42 C.F.R. 405.860. If the amount in controversy is greater than $500, then the hearing officer's decision may be appealed to an HHS administrative law judge (ALJ), with additional administrative review available before the HHS Appeals Council. 20 C.F.R. 404.929 *et seq.*, 404.967 *et seq.*, as made applicable to the Medicare Program by 20 C.F.R. 404.900. If a written request for Appeals Council review is not filed within 60 days and the time for filing is not extended, then the Appeals Council will dismiss the case. 20 C.F.R. 404.971. By regulation (20 C.F.R. 404.972), "[t]he dismissal of a request for Appeals Council review is

binding and not subject to further review." In addition, if the claimant does not seek Appeals Council review of an ALJ decision within the time allowed, the ALJ's decision is binding on the claimant on the merits. 20 C.F.R. 404.955(a) and (b). By contrast, if a request for review is timely and the Appeals Council either reviews or declines to review the case, then its decision (or the ALJ's decision, if the Appeals Council denies a timely request for review) constitutes the final administrative decision. 20 C.F.R. 404.981. Judicial review of a final administrative decision must be taken within 60 days after the mailing to him of the decision or within such further time as the Secretary may allow. 42 U.S.C. 1395ff(b)(1) (incorporating 42 U.S.C. 405(g)).

2. Petitioner, a specialist in internal medicine, practices in Huntsville, Alabama. Pet. 5. During fiscal years 1986 and 1988, petitioner supplied services to Medicare patients and then submitted bills to the carrier for payment. Based upon initial determinations, petitioner was paid for those claims as billed. Subsequently, the carrier conducted post-payment audits of those years, which gave rise to the two overpayment determinations at issue here. See Pet. App. B1-B2.

The first overpayment dispute concerns petitioner's practice of billing for both endoscopy procedures and office visits for the same patient on the same day. Pet. App. B2 & n.2. That practice, which was clearly prohibited by carrier policy, resulted in an overpayment of $508.47. *Id.* at B3. The carrier's determination was upheld by a fair hearing officer and subsequently by the ALJ. *Ibid.* The ALJ held that the carrier's authority to develop Medicare guidelines for payment of claims and to determine what evidence

is acceptable to establish "medical necessity" comes from section 5240 of the Program Administration Manual. App., *infra*, 7a-8a.[1] The ALJ found further that carrier policy clearly prohibited double billing for endoscopy and an office visit on the same day. *Id.* at 8a. Since the local practice established by the carrier's policy resulted in the lowest cost, the ALJ agreed with the carrier that the charge for global services rather than two separate charges for those services is the "reasonable cost" for those services, and that petitioner was on notice of that policy. *Ibid.* The ALJ also found that petitioner was not without fault in causing or accepting overcharges because petitioner should have known that double billing for same day services was not reasonable as determined by the carrier. *Id.* at 9a.

The second overpayment dispute, amounting to $4,616.43, largely concerns the prohibited practice of "fragmenting" service codes[2] by, for example, billing

---

[1] See Decision of the ALJ re FY 1986, App., *infra*, 1a-11a.

[2] Medical services are classified under medical procedure codes developed by the American Medical Association. See Decision of the ALJ re FY 1988, App., *infra*, 17a. Section 5246.4 of HCFA's Manual states that when the level of service reported on the claim form is not reasonable and necessary (*i.e.*, when it has been determined that a less expensive level of service would have met the patient's medical need, or when a less expensive level of service was actually furnished), reimbursement must be based on the reasonable charge for the less expensive level of service. *Id.* at 17a-18a. Section 3045.1A of the Carriers' Manual prohibits fragmentation of assigned charges made under Medicare Part B. *Id.* at 18a. Other errors found included charging for a higher level of service than was established to be medically necessary by the records. *Id.* at 15a-16a. That is, there were no test results or interpretations of tests to verify that the tests were

for a beneficiary's urinalysis conducted on the same day under multiple subcodes instead of billing once under the global code for that process. App., *infra*, 15a. The carrier's determination was upheld by the fair hearing officer[3] and then by the ALJ. *Id.* at 15a-16a.

Petitioner requested Appeals Council review of the ALJ's decisions in these two disputes well over 60 days after notice of each was mailed to him. Pet. App. B3, B4. Petitioner was notified that his requests for review were untimely and would be dismissed unless he could demonstrate "good cause" for the late filing. *Ibid.* Petitioner responded in conclusory terms that he did not receive timely notice of the ALJ's decision and that his request for review was timely. *Ibid.* He did not specify the date on which he received the ALJ's decision, nor did he submit any postmark evidence. *Id.* at C2, C4. The Appeals Council found that petitioner failed to demonstrate "good cause" and dismissed both requests for review, leaving the ALJ's decisions as the final decisions of the Secretary. *Ibid.*

3. Petitioner then filed this suit in district court under 42 U.S.C. 1395ff(b) (incorporating 42 U.S.C. 405(g)), challenging the Secretary's overpayment determinations on statutory and due process grounds

---

indicated or were anything more than routine. *Id.* at 15a. In such instances, the Hearing Officer downgraded the services, with a corresponding reduction in the amount of the insurance payment that was proper. *Id.* at 15a-16a.

[3] When petitioner refused initially to submit any documentation to substantiate his charges, the carrier used a statistical random sample to project an overpayment of $28,729.30. Pet. App. B4. However, after petitioner agreed to cooperate, the overpayment was redetermined on the basis of an analysis of the sample claims under review for that year.

and seeking a refund of amounts recouped by the Secretary. In particular, petitioner questioned the authority of the carrier to conduct a post-payment audit, to rely on its own published policy as to what constitutes a "reasonable charge," and to establish the proof requirements, all without following the notice and comment procedures under the Administrative Procedure Act (APA), 5 U.S.C. 553. Pet. App. B11-B12. Additionally, petitioner challenged the denial of subpoena power and discovery prior to the administrative hearing, and the Appeals Council's dismissal of his requests for review of the ALJ's decisions as untimely. *Id.* at B9-B11. He also challenged the final overpayment determination in the second dispute as a prohibited "penalty" under the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.*, because it was based upon an audit of documents the production of which was not specifically authorized pursuant to that Act. Pet. App. B12-B14.

The Secretary moved to dismiss the action for lack of subject matter jurisdiction or for summary judgment, pointing out that judicial review is limited to final decisions of the Secretary (42 U.S.C. 405(g)); that, pursuant to 20 C.F.R. 404.972, the Appeals Council's dismissal of petitioner's request for review as untimely was not a judicially reviewable "final decision" (Pet. App. B6); that, even if the Appeals Council's dismissal were a reviewable final decision, it was based on a proper exercise of discretion; and that, in any case, petitioner's legal challenges to the underlying ALJ decisions were without merit (*id.* at B11, B12, B14).

The district court held that it had jurisdiction to review the Appeals Council's dismissal pursuant to controlling Eleventh Circuit precedent, *Bloodsworth*

v. *Heckler*, 703 F.2d 1233, 1239 (1983). Pet. App. B7. The court determined, however, that the Appeals Council did not abuse its discretion in applying the "good cause" criteria for excusing a failure to meet the deadline for seeking administrative review, set forth in 20 C.F.R. 404.911 (Pet. App. B8), or act arbitrarily or capriciously in denying petitioner's requests for review based on his failure to demonstrate good cause for the delay in filing for review (*id.* at B10). The court upheld as reasonable the Appeals Council's determination that petitioner failed to establish a credible explanation for the untimely filings, in the absence of any evidence of the date petitioner actually received notice. *Ibid.*

On the merits of the ALJ's decisions, which it held to be final agency decisions for purposes of judicial review, the district court granted summary judgment for the Secretary. In particular, the court held that the carrier's post-payment audits were conducted in a manner consistent with the Medicare Act, the APA, and due process requirements (Pet. App. B11-B12); that neither the Social Security Act nor the APA provides for prehearing discovery at the administrative level, and that such an opportunity is normally not available (*id.* at B11); and that petitioner had no right to subpoena the Medicare Carrier's Manual or to subpoena Medicare officials to address petitioner's coding practices in prior unrelated audits (*ibid.*). Additionally, the court rejected petitioner's argument that the carrier policy statements on which the overpayment determinations were made were procedurally defective. It held that such materials constitute "interpret[at]ive rules, general statements of policy, or rules of agency organization, procedure or practice," which are expressly exempt from the

APA's notice and comment requirements. *Id.* at B12 (quoting 5 U.S.C. 553(b)(3)(A)).

Finally, the court rejected petitioner's claim that the Secretary's overpayment determination in the second dispute constituted a prohibited "penalty" under the Paperwork Reduction Act because it was based upon petitioner's failure to produce medical records for which no OMB number had been assigned. Pet. App. B12-B14. Observing that petitioner had no right to any Medicare payment for which he could not document "reasonable cost," the court held that the determination of the amount owing was not a "penalty" but rather a decision concerning the amount of Medicare funds incorrectly paid to petitioner. *Ibid.* The court also upheld the carrier's right to project an overpayment when no documentation on the audited random sample is forthcoming, holding that "HHS has authority to make projections concerning overpayments using a random sampling method when the underlying circumstances do not permit a case by case review. The use of a random sample does not constitute a 'penalty' under the Act." *Id.* at B14.

4. In an unpublished *per curiam* decision, the court of appeals affirmed the district court's order affirming the Secretary's determination that petitioner was overpaid. Pet. App. A1. The court found his arguments based on the APA, the Paperwork Reduction Act, and due process to be without merit, and held that petitioner had waived all other arguments raised on appeal. *Ibid.*

ARGUMENT

The arguments petitioner raises are without merit for the reasons given by both lower courts.[4] The holdings of the court of appeals do not conflict with a decision of this Court or of any other court of appeals, and raise no important question of general

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[4] Because petitioner failed to seek review of the ALJ's decisions within the 60-day period allowed, the district court lacked subject matter jurisdiction over this action. As the district court noted (Pet. App. B6), the Eleventh Circuit in *Bloodsworth* v. *Heckler*, 703 F.2d 1233, 1239 (1983), held that, in the circumstance where a review request to the Appeals Council is dismissed as untimely, the ALJ's decision constitutes the "final agency decision," and it may be reviewed in district court so long as review is sought within 60 days of the Appeals Council's dismissal. The court acknowledged that the Eleventh Circuit is the only circuit holding that the district court has jurisdiction to review an Appeals Council decision dismissing an untimely appeal from an ALJ decision. Pet. App. B7. Seven other circuits have rejected that position. See *Bacon* v. *Sullivan*, 969 F.2d 1517, 1520-1521 (3d Cir. 1992); *Matlock* v. *Sullivan*, 908 F.2d 492, 494 (9th Cir. 1990); *Turner* v. *Bowen*, 862 F.2d 708, 709-710 (8th Cir. 1988); *Harper* v. *Bowen*, 813 F.2d 737, 741 (5th Cir.), cert. denied, 484 U.S. 969 (1987); *Adams* v. *Heckler*, 799 F.2d 131, 133 (4th Cir. 1986); *Dietsch* v. *Schweiker*, 700 F.2d 865, 867 (2d Cir. 1983); *Watters* v. *Harris*, 656 F.2d 234, 238-239 (7th Cir. 1980). Even if a court may review the Appeals Council's dismissal of an appeal as untimely, however, it does not follow that where, as here, the court upholds the Appeals Council's dismissal of the appeal, it may nevertheless go on to review the ALJ's decision on the merits. In that situation, the ALJ's decision is binding on the claimant, see 20 C.F.R. 404.955(a) and (b), and the claimant's procedural default in failing to seek timely Appeals Council review would bar the district court from reviewing the ALJ's decision on the merits.

importance.[5] Accordingly, certiorari is not warranted.

1. Petitioner's due process claims (Pet. 23-24) lack merit. The courts below correctly held that petitioner was not entitled to conduct prehearing discovery at the administrative level (Pet. App. A1, B11)[6] or to introduce testimony of Medicare officials about unrelated medical reviews (*ibid.*). Nothing in either the Medicare Act or the APA provides such rights, *ibid.*; see also *Small* v. *Sullivan*, 820 F. Supp. 1098, 1106 (S.D. Ill. 1992); cf. *Hummel* v. *Heckler*, 736 F.2d 91, 93 (3d Cir. 1984), and no court has held to the contrary.

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[5] Since petitioner obtained judicial review of both ALJ overpayment determinations, the question whether the Appeals Council acted improperly in dismissing petitioner's request for review as untimely is essentially irrelevant. The APA, due process and Paperwork Reduction Act arguments discussed below are the only issues that petitioner preserved for review. Pet. App. A1. Accordingly, all of the other questions presented in the petition should be disregarded. See *Citizens Bank of Maryland* v. *Strumpf*, 116 S. Ct. 286, 290 n.** (1995) (Court will decline to address contentions not raised below).

[6] While the issuance of subpoenas in connection with an ALJ hearing may be appropriate "[w]hen it is reasonably necessary for the full presentation of a case," 20 C.F.R. 404.950(d), petitioner failed to establish such a need here. Petitioner sought to subpoena the Medicare Carrier's Manual, a published document that is readily available to the public. Pet. App. B11. Given petitioner's subsequent reliance on portions of that Manual (see, *e.g.*, Pet. 22), a subpoena clearly was not necessary. Nor was carrier testimony as to "technical coding questions" on unrelated, earlier claims (Pet. 24) relevant to whether petitioner's bill coding on the claims audited here conformed with the carrier's policy.

2. The courts below also correctly rejected petitioner's contention (Pet. 25; see Pet. App. B11) that the "Carrier Bulletins," "periodic publications issued by the carrier" and "payment guidelines" issued by, and relied upon by, the carrier failed to comply with the notice and comment requirements of the APA, 5 U.S.C. 553(b)(3)(A). Pet. App. A1, B11. The APA's publication and notice and comment requirements apply to "substantive rules of general applicability adopted as authorized by law." 5 U.S.C. 552(a)(1)(D). Section 553(b) of the APA requires that an agency publish a notice of proposed rules in the Federal Register for public comment, subject to certain exceptions. 5 U.S.C. 553(b). The APA exempts from its notice and comment requirements "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. 553(b)(3)(A). "Carrier Bulletins," "periodic publications issued by the carrier," and "payment guidelines" are thus exempt from the APA's notice and comment requirements. See *Shalala* v. *Guernsey Memorial Hosp.*, 514 U.S. 87, 99 (1995); see also *Mile High Therapy Centers, Inc.* v. *Bowen*, 735 F. Supp. 984, 986 (D. Colo. 1988) (HCFA ruling explaining Medicare's use of statistical sampling method for audits and computing overpayments held exempt from APA notice and comment requirements); accord *Chaves County Home Health Services, Inc.* v. *Sullivan*, 732 F. Supp. 188, 191 (D.D.C. 1990), aff'd, 931 F.2d 914, 923 (D.C. Cir. 1991), cert. denied, 502 U.S. 1091 (1992). At the same time, however, those carrier materials do not have the force and effect of law, and they therefore do not bind the ALJ or the

Appeals Council in the adjudication of claims. See *Guernsey Memorial Hosp.*, 514 U.S. at 99.[7]

3. Petitioner's Paperwork Reduction Act (PRA) claim (Pet. 21-23) lacks merit. Petitioner contends that the Secretary's overpayment decision regarding fiscal year 1988 must be set aside as violative of the PRA because it was based on petitioner's failure to produce documents as to which the Secretary failed to obtain a separate OMB control number. Pet. 22. In the absence of a control number for this document request, petitioner argues, the PRA relieved petitioner of any duty to respond to the audit.

While petitioner is correct in asserting that the PRA prohibits penalizing a person "for failing to maintain or provide information to any agency if the information collection request * * * does not display a current control number assigned by the Director [of the Office of Management and Budget]," 44 U.S.C. 3512, the Secretary's overpayment determinations below did not constitute a "penalty." Pet. App. A1, B14. As a physician, petitioner is not required to participate in the Medicare program, but if he does, he is subject to program requirements. As noted above, a physician may bill Medicare only for medically reasonable and necessary services and procedures and must adequately document such medical reason-

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[7] Petitioner relies (Pet. 25) heavily on *Glick* v. *Secretary of Health and Human Services*, 714 F. Supp. 39 (D. Mass. 1989), for the proposition that he was not given adequate notice of the types of documentation necessary to establish that his bills constituted reasonable and necessary costs. *Glick* is distinguishable. In that case, there were no clear documentation requirements for participating psychiatric practitioners. See *id.* at 41. Here, by contrast, documentation requirements were explicit. App., *infra*, 16a-17a.

ableness and necessity. See 42 U.S.C. 1395*l*(e). As petitioner concedes (Pet. 23), the claim form on which he submitted his original bills contained an OMB control number. Petitioner was on notice of his continuing obligation under the Medicare Act to substantiate his claims as required by the carrier. Treating an inadequately documented bill as medically unreasonable or unnecessary for Medicare purposes is not an imposition of a penalty. It is merely a finding that Medicare money was erroneously paid to the physician and must be returned.[8]

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[8] To the extent petitioner complains about the carrier's initial assessment of overpayment, an amount derived by extrapolation from a random sample of claims as to which he refused to subnit any documentation, his contention is without merit. The practice of statistical sampling and extrapolation to determine Medcare overpayments has been upheld by the few courts that have considered the question. See *Mile High Therapy Cente, Inc.* v. *Bowen*, 735 F. Supp. at 986; *Chaves County Home Health Service, Inc.* v. *Sullivan*, 931 F.2d 914, 918-919 (D.C. Cir. 1991) (upholding statistical sampling audits in Medicare Part A), cert. denied, 502 U.S. 1091 (1992); cf. *Illinois Physicans Union* v. *Miller*, 675 F.2d 151, 156 (7th Cir. 1982) (sampling audits to recoup Medicaid overpayments). Petitioner's objection is also moot. Once petitioner acquiesced in an audit, the final overpayment amount was revised to reflect only the amount due on the sample claims after a claim-by-claim adjudication.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JULY 1997

APPENDIX A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

DECISION

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	SUPPLEMENTAL MEDICAL INSURANCE BENEFITS
Multiple Beneficiaries (Beneficiaries)	Multiple (HIC #)
Blue Cross and Blue Shield of Alabama (Carrier)	000-49-0156 (Docket Number)

This case is before the undersigned Administrative Law Judge on a request for hearing filed on February 7, 1989. An oral hearing was held on February 20, 1992 in Huntsville, Alabama. The appellant was present at the hearing. Also present was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits as well as testimony given at the hearing.

ISSUES

The issue in this case is whether the appellant has been overpaid by $508.57 for medical services provided

to multiple Medicare beneficiaries between January and June 1987.

DECISION

It is the decision of the undersigned Administrative Law Judge that pursuant to Part B of Title XVIII of the Social Security Act, the carrier correctly determined that the appellant had been overpaid by $508.57. Since the appellant was not without fault in causing or accepting the overpayment, recovery of the overpayment cannot be waived.

EVALUATION

Section 1842(a) of the Social Security Act establishes the carrier's responsibility to audit records and assure that proper reimbursement has been made for medical services. Section 1861(v)(1)(A)(ii) of the Act instructs carriers to make suitable "retroactive corrective adjustments" to payments when necessary.

The appellant is a specialist in internal medicine who practices in Huntsville, Alabama. In a letter dated August 31, 1988, the Medicare carrier, Blue Cross and Blue Shield of Alabama, notified the appellant that it had conducted a postpayment review of claims he submitted for services provided to multiple Medicare beneficiaries between October 1, 1986 and September 30, 1987. An overpayment of $1421.09 was identified and the appellant was instructed to send a check for this amount to the carrier. The carrier found that the appellant had incorrectly been paid for office visits provided on the same dates as endoscopy procedures in contravention of carrier policy. Both the endoscopy procedures and office visits were allowed at the full reasonable charge profile amounts.

Since the Administrative Law Judge cannot consider claims for services provided before January 1, 1987, the request for hearing for claims involving services provided before that date has been dismissed. Claims for 23 beneficiaries are still at issue. The overpayment amount for services provided after January 1, 1987 is $508.57. Since the remaining overpayment amount is over the $500.00 amount in controversy requirement and the claims involve "common issues of fact and law," the claims can be aggregated under Section 1869(b)(2)(B) and the undersigned Administrative Law Judge has jurisdiction to hear the case.

Briefly, the Medicare law and regulations provide reimbursement to Part B enrollees on expenses for covered health services and supplies on the basis of a "reasonable charge" (allowable amount). This "reasonable charge" is determined by the carrier, based on data collected from previous Medicare claim experience whenever possible. The collection process is accomplished by means of a procedure (service) identification coding system and actual charges for those procedures which have been billed to the Medicare program. This code and charge information is compiled during an entire 12 month fiscal year from July 1 through June 30. This data is used to price new claims for services rendered beginning January 1st of the next year.

The Omnibus Budget Reconciliation Act, Public Law 99-509, provides that services rendered by Medicare participating physicians during the period January 1, 1989 through December 31, 1989 are to be priced on claim data received during a 12 month, July 1, 1987 through June 30, 1988, fiscal year period. This legislation also maintained the Social Security Amend-

ments of 1972 which imposed a economic index limit of annual fiscal year increases to prevailing charge data (taken from 1971 claim charges) being the base of measurement for each subsequent annual increase.

When selecting a reasonable charge for a specific service, there must be considered 4 primary sources of charge information:

(1) the provider's median charge for the service during July 1, through June 30 preceding fiscal year period;

(2) the prevailing charge by other physicians of the same specialty in the same region during the same fiscal year period for the same service;

(3) the fiscal year 1973 prevailing charge for the service increased by the Medicare Economic Index (MEI); and

(4) the physician's charge on the claim at hand.

Reasonable, as used in the term "reasonable charge", is strictly defined by the law and regulation, and not subject to interpretation. The reasonable charge, by law, is the *lowest* of the above 4 criteria.

The appellant requested a carrier Fair Hearing on October 23, 1988. The hearing was conducted by telephone on January 4, 1989 and a decision was issued on January 20, 1989. The Hearing Officer upheld the carrier's determination of the overpayment, stating:

> The endoscopy procedure is considered to be surgery. Medicare guidelines do not allow the payment of medical visits in the office on the same day that the provider performs surgery because the surgery fee is considered global in nature and should include the cost of medical visits on the same day. Therefore, the carrier was correct in denying payment for the office visits . . .

The appellant argues that Medicare should cover charges for endoscopy and office visits provided on the same day whenever the charges are for two separate medical conditions and that Medicare should deny payment for the visit only when the office visit charge is for routine pre-operative or post-operative care for the concurrent surgery.

The appellant cites the 1988 Physicians Current Procedural Technology (CPT) coding handbook as supporting his position that an office visit provided on the same day as an endoscopy can be allowed. He believes that the carrier should follow the instructions given in the CPT. Paragraph 3 of the "Surgery Guidelines" section of the CPT states:

> FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES, e.g. endoscopy, injection procedures for radiography, includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

However, the undersigned notes that the carrier is not required to follow the guidelines in the CPT. The

surgery guidelines are not binding on the carrier but may be useful in processing surgery claims.

The appellant also submitted responses to questions he sent to several other Medicare carriers. He asked whether the carriers follow the CPT, whether they pay for both an endoscopy and an office visit performed on the same day when two diagnoses are listed, and whether they pay for an endoscopy and an office visit performed on the same day when only one diagnosis is listed. Most of the carriers who responded to his inquiry indicated that they would pay for an office visit provided on the same day as an endoscopy. However, several carriers indicated that they would pay for the office visit and the endoscopy only if the claim showed different diagnoses for the two services. One carrier, Blue Cross and Blue Shield of North Dakota, indicated that payment for both the endoscopy and office visit would depend on what endoscopy procedure was billed. These responses indicate that there is some variation in how other carriers pay these claims. In addition, several carriers indicated that they do not strictly follow the CPT guidelines for surgery. Equicor of Tennessee indicated that it has adopted some of the surgical guidelines listed in the CPT. However, in some situations its carrier policy guidelines would differ from the CPT.

Blue Cross and Blue Shield of Alabama's policy regarding this issue was explained in Medicare Bulletins dated May 1982 and January 1984. The Bulletins state that an office visit performed on the same day as surgery will be denied because the surgery fee is considered to be "global" and includes payment for the office visit. Since endoscopy is considered to be a

surgical procedure, no payment can be made for an office visit provided on the same day.

At the hearing before the undersigned, the appellant stated that the carrier will allow payment for an endoscopy and another procedure done on the same day but it will not allow payment for the endoscopy and an office visit. He noted that the office visits were related to different diagnoses and that he documented the services he provided. Also testifying at the hearing was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. She indicated that the allowance for the endoscopy procedure is sufficient to adequately reimburse a physician for an office visit. She noted that this policy was based on carrier guidelines written prior to the dates of service at issue. She indicated that the Health Care Financing Administration (HCFA) gives carriers the right to develop their own guidelines based on the standard of practice in the locality. If HCFA does not state exactly what procedures a carrier must follow, the carrier can develop its own guidelines regarding how claims should be allowed.

The carrier states that its authority to develop medical guidelines for payment for Medicare claims comes from Section 5240 of the Program Administration Manual. Section 5240 of the Program Administration Manual states that carriers retain the authority to determine medical guidelines for payment and to determine what evidence is acceptable to establish medical necessity.

After the reviewing the evidence presented in this case, the undersigned finds that the carrier correctly determined that the appellant has been overpaid by

$508.57 for office visits which should not have been separately paid. Carrier policy clearly states that office visits provided on the same day as surgical procedures, such as an endoscopy, should be denied as being included in the global fee for the surgery. Although, carriers in other jurisdictions may follow different policies on this issue, Blue Cross and Blue Shield of Alabama is not required to follow the guidelines utilized by carriers in other areas. Carrier guidelines are based on medical practice in the *locality*, not on practice in other states or areas. In addition, the carrier also is not bound to follow the surgery guidelines provided in the CPT. As stated above, this publication is not binding on carriers and its guidelines may be subject to local interpretation.

Since the overpayment has been upheld, the issue of whether the appellant was "without fault" in causing or accepting the overpayment must be considered. Section 1870 of the Social Security Act states that repayment of an overpayment cannot be ordered if the provider of services is without fault. Pursuant to Section 1870(c) of the Act, repayment will not be ordered for cases in which repayment would defeat the purposes of Title XVIII of the Act or would be against equity and good conscience.

Section 7100 of the Carriers Manual explains liability for overpayment and states that "once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government." Section 7103 of the Carriers Manual explains physician liability for overpayment. Section 7103 states that a physician is without fault if he or she exercised reasonable care in billing for and accepting the payment. Reasonable care is estab-

lished if: (1) the physician complied with all pertinent regulations, and (2) the physician made full disclosure of all material facts, and (3) on the basis of the information available, including but not limited to the Medicare regulations, the physician had a reasonable basis for assuming that the payment was correct, or if the physician had reason to question the payment, the question was brought promptly to the carrier's attention. Section 7103 Carriers Manual.

Therefore, in order to find that the appellant was without fault, the appellant must show that he complied with all pertinent regulations and instructional materials, made full disclosure of all material facts and had a reasonable basis for assuming that the payments were correct, or if he did not, he brought the improper payments to the attention of the carrier. After a careful examination of the record, the undersigned finds that the appellant was not without fault in causing or accepting the overpayment. The undersigned notes that it is the physician's responsibility to comply with Medicare policies and rules which are published in the Federal Regulations, which the carrier has circulated among the medical community, and which the carrier has given to particular physicians. Carrier policy regarding payment for office visits performed on the same day as an endoscopy has been communicated to physicians in carrier Medicare bulletins. Since the appellant is held to have been aware of this policy and did not bring the overpayments to the attention of the carrier, he cannot be considered to be without fault in the overpayment.

FINDINGS

After a careful consideration of the entire record, including the testimony given at the hearing and additional evidence submitted by the appellant, the Administrative Law Judge finds that:

(1) The appellant, John H. Lary, Jr., M.D., received a total overpayment of $508.57 for medical services provided to 23 Medicare beneficiaries between January 28, 1987 and June 9, 1987.

(2) The appellant was not without fault in causing or accepting the overpayment because he did not comply with Medicare instructions and regulations regarding billing for medical services.

(3) Accordingly, recovery of the overpayment cannot be waived.

DECISION

It is the decision of the undersigned Administrative Law Judge that the appellant was overpaid by $508.57 for medical services provided between January 28, and June 9, 1987. Since the appellant was not without fault in causing or accepting the overpayment, recovery of this amount cannot be waived.

/s/ GEORGE M. JACOBS
GEORGE M. JACOBS
Administrative Law Judge
Office of Hearings and Appeals
P.O. Box 10359
Arlington, VA 22210-9998
Date Mar. 26, 1992

APPENDIX B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

DECISION

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	SUPPLEMENTAL MEDICAL INSURANCE BENEFITS
Multiple Beneficiaries (Beneficiaries)	Multiple (HIC #)
Blue Cross and Blue Shield of Alabama (Carrier)	000-40-1076 (Docket Number)

This case is before the undersigned Administrative Law Judge on a request for hearing filed on September 5, 1990. An oral hearing was held on February 20, 1992 in Huntsville, Alabama. The appellant was present at the hearing. Also present was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits as well as testimony given at the hearing.

ISSUES

The issue in this case is whether the appellant has been overpaid by $5616.22 for medical services

provided to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989.

DECISION

It is the decision of the undersigned Administrative Law Judge that the overpayment amount is reduced by $999.79 to $4616.43. The carrier is instructed to refund this amount to the appellant. The remaining overpayment of $4616.43 is upheld. Since the appellant was not without fault in causing or accepting the overpayment, recovery of the remaining overpayment cannot be waived.

EVALUATION

Section 1842(a) of the Social Security Act establishes the carrier's responsibility to audit records and assure that proper reimbursement has been made for medical services. Section 1861(v)(1)(A)(ii) of the Act instructs carriers to make suitable "retroactive corrective adjustments" to payments when necessary.

Health Care Financing Administration (HCFA) Ruling 86-1 indicates that carriers can use statistical sampling to project overpayments to providers when claims are voluminous and reflect a pattern of erroneous billing or overutilization, and when a case-by-case review is not administratively feasible. HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare. They are binding on all components, including Administrative Law Judges who hear Medicare appeals (42 CFR 401.108).

The appellant is a specialist in internal medicine who practices in Huntsville, Alabama. In a letter dated January 8, 1990, the Medicare carrier, Blue Cross and Blue Shield of Alabama, notified the appellant that it would be conducting a postpayment review of claims he submitted for services provided to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989. Medical records for a random sample of beneficiaries were requested by the carrier. However, the appellant elected not to comply with this request, indicating that it would be an unduly burdensome task. Consequently, the carrier determined that its recourse in such a case was to declare all payments made on the total universe of claims processed during the review period to be in error and request refund of those payments. On March 12, 1990, the carrier notified the appellant of the results of its review. The carrier's medical staff projected an overpayment of $28,729.30 based on a statistical random sample. The appellant was requested to forward a check for this amount to the carrier.

A carrier Fair Hearing was requested on March 14, 1990. After several postponements, a hearing was conducted on July 2, 1990 in Huntsville, Alabama and a decision was issued on August 3, 1990. At the Hearing, the appellant submitted the medical records for the sample claims that the carrier had previously requested. The Fair Hearing Officer in turn asked the carrier to have its medical staff evaluate the medical records, give its recommendations, and calculate any appropriate adjustments to the overpayment previously determined.

After reviewing the medical records, the carrier Utilization Review Committee recalculated the over-

payment at $5616.22. The carrier provided the Hearing Officer with a revised list of reasons for denying specific services. The most common error found during the second review was fragmentation of CPT codes. For example, the appellant billed for urinalysis procedures provided to the same beneficiary on the same day under procedure codes 81015, 81004 and 81005 when the proper code to bill for urinalysis, (specific gravity, protein, tests for reducing substances for glucose) was 81000. Urine culture and sensitivity tests billed under codes 87086, 87088 and 87184 should have been billed under P7001. Very few of the services were denied for lack of documentation to support medical necessity. Claims for testing of stool samples were incorrectly billed based on the number of specimen cards rather than for the complete test.

Claims billed under procedure code 93000 (routine ECG with at least 12 leads; with interpretation and report) were reduced to 93005 when the reviewers could not find evidence that the appellant had performed the interpretations. The carrier also stated that ECG services Q0020, Q0021 and Q0022 are included in Q0019 and should not be billed separately. Claims for diagnostic tests which were not supported by test results were denied even though the appellant had submitted charge slips for the services. Office visits were reduced to meet the descriptions in the CPT manual. The most noticeable error was billing procedure code 90080 for what appeared to be routine visits.

The Hearing Officer stated in his decision that in accordance with instructions from HCFA, the carrier is required to pay claims under the procedure code

that reflects the lowest cost to the Medicare program. Consequently, the Hearing Officer upheld the carrier's denials or downgrades of services in all cases that failed to conform to this policy. For example, urine culture and sensitivity studies were billed by the appellant under codes 87086, 87088 and 87184, all performed on the same patient on the same day. While, these codes are valid codes, the three services should have been combined under code P7000, which is reimbursable at a lower cost to Medicare. The Hearing Officer noted that all Alabama providers were first notified of the P7000 code for use in billing urine culture and sensitivity studies in Carrier Bulletin #84-28 dated June 1984. Subsequent updates have also included this code. The Hearing Officer noted that the appellant had fragmented charges for urinalysis procedures by billing codes 81015, 81004 and 81005 when 81000 included all of the services provided. The October 1986 issue of Providerfax sent to all Alabama providers, warns providers against fragmenting claims for laboratory tests. The Hearing Officer also stated that Section 3045.1A of the Medicare Part B Carriers Manual prohibits fragmentation of charges.

The Hearing Officer upheld the carrier's decision to downgrade 12 lead ECG services from 93000 to lower levels of service because evidence in the file did not document the medical necessity of the more extensive service. In discussing the lack of copies of the results of certain laboratory tests and the fact that the appellant provided charge slips for the services, the Hearing Officer noted that carrier policy requires all providers to submit copies of the actual test results as verification that the test was conducted. In addition, information contained in the laboratory reports

provides evidence regarding the medical necessity of the services. Charge slips do not allow the carrier to determine whether the services were medically necessary. Therefore, the Hearing Officer held that the carrier had correctly denied payment for these tests.

Accordingly, the Hearing Officer held that carrier policy should be followed regarding the use of correct codes for particular services. Therefore, the Hearing Officer held that the overpayment had been correctly calculated at $5616.22.

In most claims for reimbursement under Medicare Part B, the medical services in question are classified by the physician(s) and later by the carrier under medical procedure codes. These codes were developed by the American Medical Association and are set forth in the 4th edition of Current Procedural Technology (CPT), and in the 1990 Health Care Financing Administration's Common Procedure Coding System (HCPCS).

Section 410.20 of 42 CFR allows payment for physician's services. Section 1862(a)(1)(A) of the Social Security Act states that Medicare will not pay for items or services which "are not reasonable and necessary for the diagnoses or treatment of illness or injury or to improve the functioning of a malformed body member".

Section 5246.4 of the Carriers Manual states that went the level of service reported on the claim is not reasonable and necessary; i.e., when it has been determined that a less expensive level of service would have met the patient's medical need, or when a less expensive level of service was actually furnished,

reimbursement must be based on the reasonable charge for the less expensive level of service. Section 3045.1A of the Carriers Manual prohibits fragmentation of assigned charges made under Medicare Part B.

At the Hearing before the undersigned, the appellant contended that his billing practices were correct and that the Medicare carrier was in error in its determinations regarding the use of particular procedure codes. Specifically, he contended that the carrier had improperly reduced the coding of specific services and had incorrectly determined that certain global codes should have been billed.

The appellant stated that chemical examinations of stool samples (82270) should be paid by the number of samples tested rather than as one complete test. He noted that stool samples may be collected over a period of days but all of the samples may be tested on the same day. Glucose testing was cited as an example of this type of billing. Multiple glucose tests performed on the same day are billed separately. The appellant argues that testing of multiple samples should be billed separately unless Medicare states that only one test performed on the same day can be allowed. The appellant has submitted a letter from Renate Jordan, Coding Coordinator at Huntsville Hospital, dated February 19, 1992. Ms. Jordan states that the fundamental rule of coding, billing for a service for as many times as it is performed, would apply to stool examinations billed under procedure code 82270. Therefore, if stool examinations are performed two or more times in a single day, each performance should be coded separately. However, a carrier "Provider Fax" dated January 1989 contradicts this position and instructs providers to list the

number of services provided when billing occult blood screening under code 82270. Payment of this service by Medicare and Blue Shield is for the "complete test rather than the number of specimen cards returned when the services are medically necessary". Notwithstanding the opinion of Ms. Jordan, who is not associated with Medicare, the undersigned finds that the carrier correctly determined that the stool examinations should have been billed as one complete test rather than based on the number of samples submitted.

Regarding billing for urine cultures, he stated that three separate procedures may be performed, a colony count (87086), bacterial identification (87088) and sensitivity test (87184). He noted that it is very important to identify the bacteria present in the samples in addition to the colony count. The sensitivity test is performed to see what antibiotic should be used. Therefore, he argues that all three codes should be paid. Nevertheless, Ms. Kerzic stated that most physicians bill for these tests under one global fee. There is no code in the CPT for bacterial studies. However, as noted by the Fair Hearing Officer, the carrier notified providers in a 1984 publication that the proper code for these services is P7000.

The appellant states that the carrier incorrectly determined that urinalysis tests should be combined under procedure code 81000 as one complete service. He noted that urinalysis tests may include several different procedures which should be billed separately. Ms. Kerzic testified that procedure code 81000 is a global urinalysis code which includes payment for multiple components. The 1991 HCPCS defines procedure code 81000 as "urinalysis, by regent strips,

any number of components; with microscopy". The undersigned agrees with the carrier's determination that the appellant has fragmented his charges for urinalysis tests. The correct code for these services is 81000 which includes all of the components of the services performed by the appellant. This represents the lowest cost to Medicare.

Ms. Kerzic stated that frequently the appellant did not adequately document the services he billed. In many cases, he used a check list and did not indicate the chief complaint or the symptoms which indicated why he was seeing the patient. In some cases the documentation was so poor that it was impossible to determine what service was actually performed. Rather than denying the service entirely, the carrier downcoded the claim to a lower level of service than was billed. Apparently, Dr. Lary consistently refuses to submit medical records requested by the carrier. However, in reviewing records provided by Dr. Lary prior to the hearing, Ms. Kerzic acknowledged that there was sufficient documentation to justify payment for specified billings for thirteen of the beneficiaries. Reductions in the overpayments made to these beneficiaries total over $390.00. Since the total overpayment was based on projections made from sample claims including services which have now been allowed, Ms. Kerzic agreed that she would have to recalculate the overpayment. In a letter to the undersigned dated February 25, 1992, Ms. Kerzic stated that the revised projected overpayment amount is $4616.43. The undersigned accepts this revised amount and holds that the overpayment is reduced to $4616.43. The appellant was given an additional 15

days to respond to the recalculation of the overpayment.

Following the hearing, the appellant submitted an affidavit dated March 9, 1992 and a brief entitled "Statement of the Case". These two documents have been marked as exhibits and included in the file. However, the undersigned notes that the documents repeat the same arguments which the appellant has presented in previous correspondence and at the Hearing.

The undersigned has determined that the remaining overpayment has been correctly calculated by the carrier based on improper billing and fragmentation of charges. A review of the records and the testimony presented at the hearing reveals that the appellant consistently fragments bills for separate components of tests such as urinalysis and urine cultures when the services should be billed under one global procedure code which includes all components of the tests. There are repeated examples in the record where one or more procedure codes were billed when a different code would have more accurately described the services.

The undersigned notes that the appellant has had a succession of hearings in which he raised the same issues concerning his billing practices. He argues that the Medicare practice for establishing the procedure codes to be allowed is incorrect and that he was justified in billing as he did. As noted by Ms. Kerzic, HCFA gives Medicare carriers the right to develop their own guidelines for billing particular services. These standards must of course be consistent with applicable statutes and regulations and should be

based on standards of practice in the locality. The undersigned finds that the carrier acted within its authority to develop payment guidelines for specific services such as laboratory tests. The provider community has been apprised of these guidelines in periodic publications issued by the carrier.

Since the overpayment has been upheld, the issue of whether the appellant was "without fault" in causing or accepting the overpayment must be considered. Section 1870 of the Social Security Act states that repayment of an overpayment cannot be ordered if the provider of services is without fault. Pursuant to Section 1870(c) of the Act, repayment will not be ordered for cases in which repayment would defeat the purposes of Title XVIII of the Act or would be against equity and good conscience.

Section 7100 of the Carriers Manual explains liability for overpayment and states that "once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government." Section 7103 of the Carriers Manual explains physician liability for overpayment. Section 7103 states that a physician is without fault if he or she exercised reasonable care in billing for and accepting the payment. Reasonable care is established if: (1) the physician complied with all pertinent regulations, and (2) the physician made full disclosure of all material facts, and (3) on the basis of the information available, including but not limited to the Medicare regulations, the physician had a reasonable basis for assuming that the payment was correct, or if the physician had reason to question the payment, the question was brought promptly to the carrier's attention. Section 7103 Carriers Manual.

Therefore, in order to find that the appellant was without fault, the appellant must show that he complied with all pertinent regulations and instructional materials, made full disclosure of all material facts and had a reasonable basis for assuming that the payments were correct, or if he did not, he brought the improper payments to the attention of the carrier. After a careful examination of the record, the undersigned finds that the appellant was not without fault in causing or accepting the overpayment. The undersigned notes that it is the physician's responsibility to comply with Medicare policies and rules which are published in the Federal Regulations, which the carrier has circulated among the medical community, and which the carrier has given to particular physicians. The appellant has consistently billed for medical services under incorrect procedures codes which resulted in incorrect payments. For example, he has consistently fragmented charges for laboratory tests. The undersigned notes that the carrier has made a concerted effort to educate physicians regarding the correct coding for specific services through Medicare bulletins. However, it is the physician's responsibility to be aware of the current usage for particular procedure codes and the coverage of particular services.

FINDINGS

After a careful consideration of the entire record, including the testimony given at the hearing and additional evidence submitted by the appellant, the Administrative Law Judge finds that:

(1) The appellant, John H. Lary, M.D., provided medical services to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989.

(2) A carrier postpayment review found that the appellant had been overpaid for these services by $5616.22.

(3) The overpayment amount should be reduced by $999.79 to 4616.43.

(4) The remaining overpayment amount is upheld.

(5) The appellant was not without fault in causing or accepting the overpayment because he did not comply with Medicare instructions and regulations regarding billing for medical services.

(6) Accordingly, recovery of the overpayment cannot be waived.

DECISION

It is the decision of the undersigned Administrative Law Judge that the appellant was overpaid by $4616.43 for medical services provided between October 1, 1988 and September 30, 1989. Since the appellant was not without fault in causing or accepting the overpayment, recovery of this amount cannot be waived.

/s/ GEORGE M. JACOBS
GEORGE M. JACOBS
Administrative Law Judge
Office of Hearings and Appeals
P.O. Box 10359
Arlington, VA 22210-9998
Date Mar. 26, 1992